# Summary Oral Health Needs Assessment:

# Understanding oral health inequalities in the North East and North Cumbria

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Dental Public Health
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# 1. Summary

Table 1 below is a quick summary guide of the major issues and what needs to be done to resolve them. The data and intelligence to support the actions are presented in Section 3 of this document.

The strategic issues presented below are not limited to organisational boundaries but highlight what needs to be done as a system, to address population oral health needs and health inequalities. Partnership working will be needed across: Integrated Care Partnerships, Local Authorities and the Department of Health and Social Care (responsibility for fluoridation).

**Table 1: Summary Table of North East and North Cumbria Strategic Issues and Areas for Action**

| Issue number | Strategic issue | What needs to be done? |
|---|---|---|
| 1 | Significant oral health inequalities exist across the North East and North Cumbria (NENC) for both children and adults. Higher rates of active dental decay are associated with higher deprivation levels, ethnicity, lack of water fluoridation and symptomatic/irregular attendance in adults.<br><br>The prevalence of dental decay doubles from age 3 to 5 in most local authority areas (data from 2020 3 year olds to 2022 5-year olds for the NENC).<br><br>Adults living in areas of high deprivation suffer more oral health impacts and more severe disease (e.g. abscesses) than those living in the least deprived areas. This higher level of unmet need places pressure on dental practices providing services in the most deprived areas.<br><br>Adults attending dental practices in Northumberland had the highest levels of active decay in the whole of the North East (43.8% versus 27.3%) three times more of an urgent treatment need (11.6% compared with 3.5%), and the highest percentage of patients requiring any treatment (84.8% compared to 75.4% in the NE). | Optimise prevention opportunities both in primary care dental settings and evidence-based community level prevention programmes. E.g. supervised toothbrushing and fluoride varnish programmes.<br><br>Target community prevention programmes to early years age groups. Commission equitable access to dental care in areas of social deprivation.<br><br>Ensure practices in the 20% most deprived populations (In line with deep end methodology) are incentivised to take on new patients with potentially higher dental needs.<br><br>Northumberland dental practices need to be considered for any incentive schemes in addition to those targeted at areas of identified deprivation as the higher level of dental treatment need identified is not consistent with deprivation levels.<br><br>Support extension of water fluoridation schemes in the North East to reduce inequalities in dental decay. |
| 2 | Access to NHS primary dental care for children in March 2022 was significantly lower (45.8%) than | Continue with short term initiatives to re-commission lost activity from existing practices and sessional activity focused |

| | | |
|---|---|---|
| | prior to the pandemic in 2020 (61.1%) in all areas of the NENC. This position is replicated for adults (39.1% compared to 56.2%). Although, the access rate recovery in the North East for adults is higher than the England average (34.1%), Cumbria (30.6%) and County Durham (33.8%) are exceptions to this. The recent number of contract hand backs across the whole of NENC will continue to make accessing care very challenging.<br><br>Adults not accessing regular care find it harder to access care as a new patient or when in pain.<br><br>Access rates for 2-year-olds are particularly low at only 35.8% in June 2022 this will reduce the opportunities for early prevention advice and intervention and to reduce decay and general anaesthetics in this young age group. | on vulnerable groups and patients in pain.<br>Re launch Dental Check By One (DCby1) campaign with local practices and Health Visitors to encourage parents to take children to the dentist as soon as they get their first teeth.<br><br>Ensure all practices but particularly practices with the 20% most deprived populations (In line with Deep End methodology) are incentivised to take on young children and deliver prevention in line with Delivering Better Oral Health guidance. |
| 3 | Significant numbers of children in NENC require access to dental care under general anaesthesia, mostly for the treatment of advanced dental decay. There are waiting times in excess of 52 weeks in some areas (NUTH and NCIC). Recovery of elective activity in North Cumbria is 50%. | Work needs to be undertaken with general anaesthesia providers to address this issue. (See Section 8 for details) |
| 4 | Vulnerable older people living in care home settings experience much more difficulty in accessing dental care. Approximately, half of all residents would find it difficult or impossible to receive urgent treatment in dental practice due to medical or psychological complications. Preventing new dental decay and slowing down the progression of existing dental decay should be a priority. | Ensure all residential homes are aware of the commissioned dental services available for urgent and routine dental care.<br><br>Ensure commissioned special care dentistry services are available for this vulnerable group.<br><br>Collaborate with Integrated Care Partnership (ICPs) to extend the Caring 4 your Smile programme in residential settings within NENC.<br><br>Evaluate the pilot fluoride varnish programme in South of Tyne and Wear (SOTW) residential care settings.<br><br>Monitor waiting times for access to domiciliary care. |
| 5 | Both incidence and mortality for oral cancers are statistically higher | Identify and sign-post individuals that would benefit from stop smoking interventions. |

| | | |
|---|---|---|
| | in the North East compared to England. Sunderland and Stockton-on-Tees are both higher for incidence and mortality in the NENC. | Identify and sign-post individuals that would benefit from reducing their alcohol consumption.<br><br>Increase dental attendance for individuals most at-risk of oral cancer, in order to identify and treat as early as possible.<br>Utilise community health champions to raise awareness of the signs and symptoms of oral cancer. |
| 6 | Residents of North Cumbria for historical reasons have the lowest Units of Dental Activity (UDAs) commissioned per head of population at 1.46 and furthermore actual delivery reduces the UDAs delivered to 0.77. (See Table 10) | Full, open and innovative procurements in North Cumbria.<br>Continue with short term initiatives to re-commission lost activity from existing practices.<br>Continue with commissioning additional sessions and top up credits to support urgent care access and access for vulnerable high needs groups.<br>Workforce initiatives to improve recruitment and retention initiatives in targeted areas with existing workforce challenges. |
| 7 | Significant number of contract hand backs is reducing equitable access to NHS dentistry across NENC. | Explore innovative procurement innovations to make NHS contracts more attractive to the market. Ensure contracts are not entirely based on achievement of UDA activity but based on a mixed service model including payments that promote: prevention activity, and the provision of urgent care, and access to new patients |
| 8 | Workforce shortages and higher treatment needs of patients presenting following limited treatment availability during the COVID period may be contributing to a significant number of contracts with under performance. Currently, 77% of contracts across NENC are identified with concerning performance at below 80% expected activity. This in turn affects the availability of routine dental care to the population, access for high needs new patients, and availability of unscheduled/urgent care for patients in pain. | Consider proactive enhanced payments to identified "high risk" practices to ensure continuing financial viability on NHS contracts. Enhanced payments could target increases in new patient access, urgent care, treatment for high needs patients and vulnerable groups and a focus on prevention.<br>Develop a menu of flexible commissioning options across NENC to incentivise and support practices to deliver urgent care, access for high needs patients and prevention initiatives.<br>Build on existing workforce recruitment and retention initiatives in targeted areas of North Cumbria, North Northumberland, Durham and Darlington. |

## 2. Introduction

The purpose of this document is to summarise and highlight the oral health needs of the population of the North East and North Cumbria. It identifies key oral health inequalities, which population groups are affected, and what is being done currently to meet these needs. Where there are gaps in prevention or treatment services and unmet needs exist, these are also brought to the attention of commissioners with options to consider. It needs to be read alongside the Rapid Oral Health Needs Assessment North East and North Cumbria (October 2022) document and a local compendium of locality profiles. Detailed analysis for each local authority or individual ICP areas has already been provided in the Rapid Oral Health Needs Assessment North East and North Cumbria and supplemented in the compendium of locality profiles. Some examples of detailed data analysis have been given for identified areas purely for illustrative purposes in this document. Five year-old dental disease data is used extensively as a proxy measure to predict needs for the adult population due to the lack of availability of adult dental data.

Tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable. Poor oral health can affect children and young people's ability to sleep, eat, speak, play and socialise with other children.

The financial costs of tooth decay are high and there is also a considerable social impact: with children missing school and parents/carers needing to take time off work to take their children to the dentist or for a hospital visit. Public Health England (PHE) report (2021), tooth decay is the most common reason for hospital admissions in the 6-10 year old age group. Waiting lists and waiting times for children requiring general anaesthesia in some parts of the North East and North Cumbria (NENC) are unacceptably high which increases morbidity for these children.

Health inequality is a common feature in dental disease; high levels of dental disease tend to affect those in low income families and those living in socially deprived conditions. Higher rates of active dental decay are associated with increasing deprivation levels, certain ethnic groups, lack of water fluoridation and symptomatic/irregular attendance in adults.

The oral health of older people has improved in England since the late 1960s, with more adults keeping their teeth into old age. However, many of these teeth will have fillings and other restorations which need continued good oral hygiene practices and regular check-ups, otherwise new decay will develop very quickly. This rapid deterioration in oral health is sometimes seen in older people that enter residential care who have lost the ability to care for their own mouths.

Oral cancer is a disease for which the outcome and prognosis can be significantly improved if it is detected early. Risk factors for oral cancer are smoking, excessive alcohol consumption and the Human Papilloma Virus (HPV) infection.

## 3. Data and Intelligence

***All data and intelligence presented below is relevant to the strategic issues identified in Table 1***

**Oral health of children and evidence of oral health inequalities (Issue 1)**

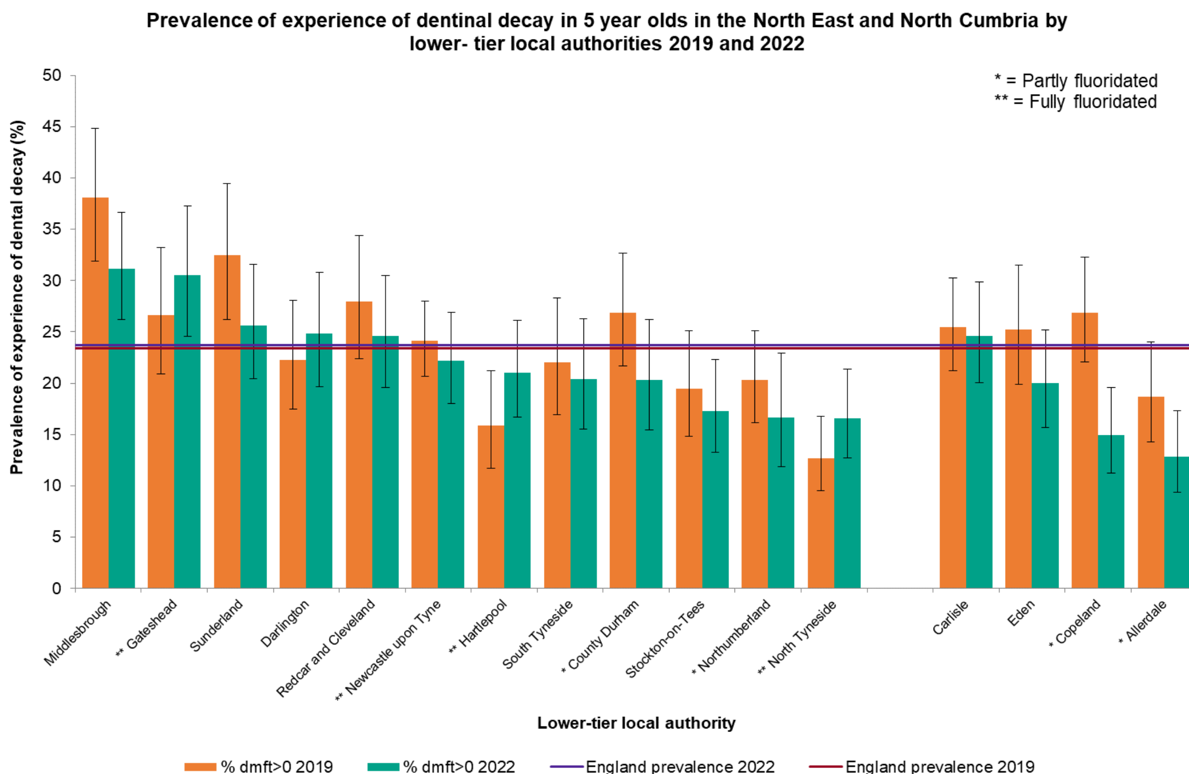
Across the NENC there has been significant improvements in oral health between 2008-2017. Since 2017-2022 there have been no significant improvements in oral health in 5-year-old children.

In the NENC 2022 survey of 5-year-old children, Graph 1 shows there is significant variation in oral health across the NENC area. Middlesbrough and Gateshead had significantly more dental decay than the England average. Stockton-0n-Tees, Northumberland, North Tyneside, Copeland and Allerdale all have significantly lower decay levels than the England average. Notably, despite having a fluoridated water supply Gateshead has worse oral health than the England average in 2022. Only Copeland which has water fluoridation has seen statistically significant improvements in oral health between 2019 and 2022. The disease data does not appear to show any consistent trends during the period of the COVID pandemic. However, this may be due to the sample sizes available being too small to be able to indicate statistically significant differences (wide confidence intervals).

Oral health inequalities are stark in all NENC areas and closely aligned to deprivation. It has not been possible to analyse the 2022 5-year-old data to show these inequalities at ward level as available sample sizes were not large enough. However, the 2016/17 census survey data analysis for local authorities is analysed at ward level. This shows a strong relationship between deprivation and the severity of dental disease in 5-year-old children. Graph 2 illustrates this point for Stockton-on-Tees. It shows that children living in the most deprived wards consistently had higher levels of decayed, missing or filled teeth than those in the least deprived wards. Additionally, levels of decayed, missing or filled teeth were consistently above the England average in the most deprived wards.

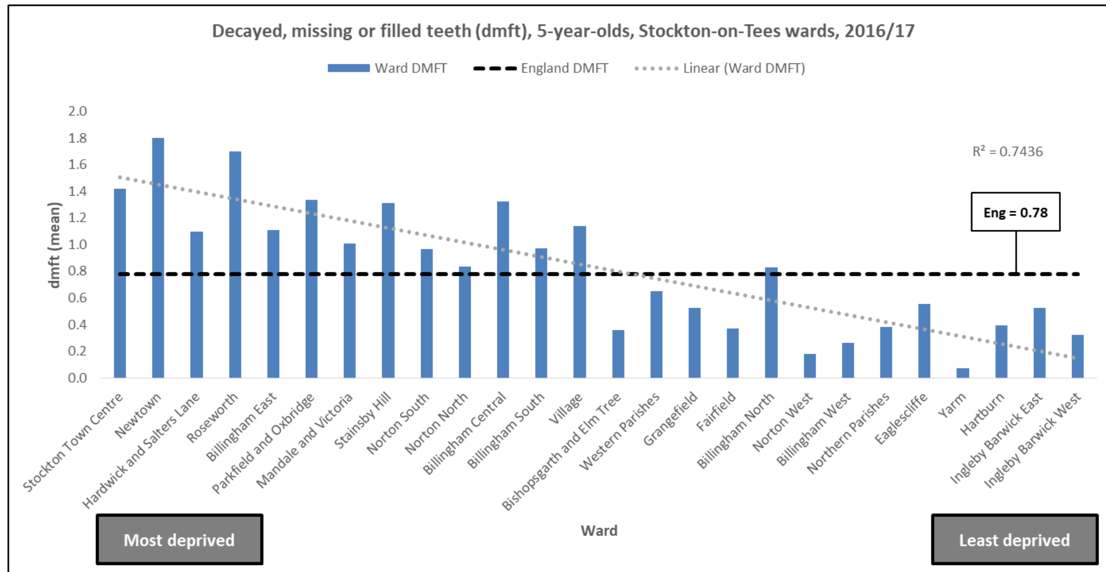
A further census survey of 5-year-old children carried out 2023/24 would provide a larger sample and enable data analysis at ward level to identify health inequalities and the impact of COVID.

**Graph 1: Prevalence of experience of dentinal decay in 5-year-olds in the North East and Cumbria by lower-tier local authorities 2019 and 2022**



**Source:** [Oral health - GOV.UK (www.gov.uk)]

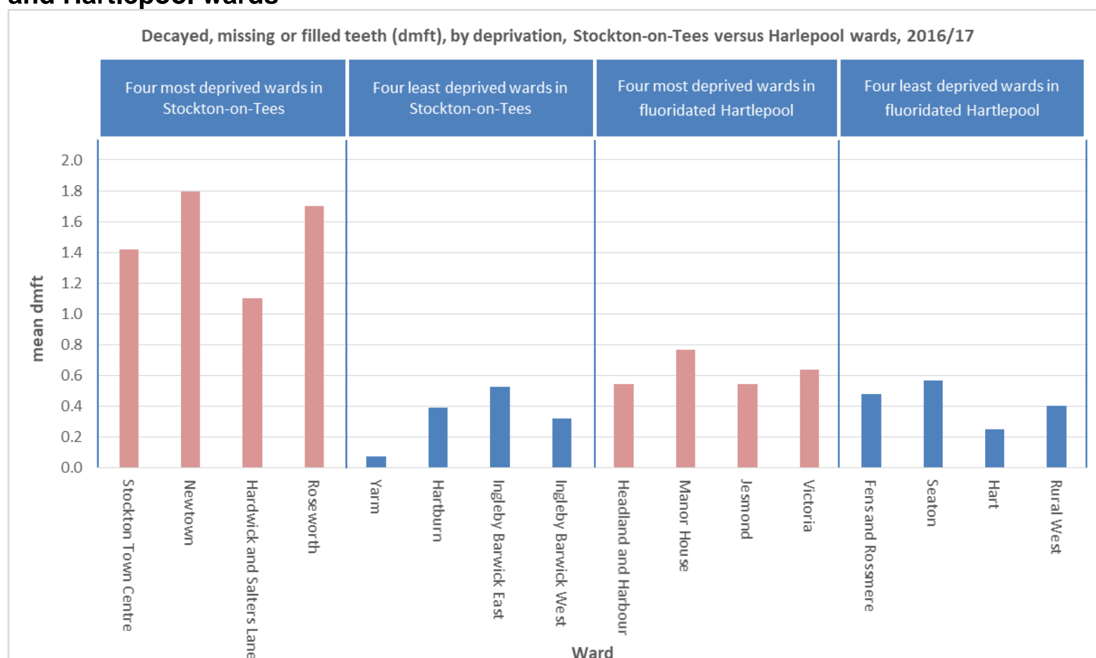
**Graph 2: Graph showing inequalities in oral health by deprivation for 5-year-old children in Stockton wards in 2016/17**




**Source:** [Oral health - GOV.UK (www.gov.uk)]

**Water fluoridation** is a public health intervention that as well as leading to overall lower levels of dental disease, mitigates the effect of deprivation. For illustration purposes, Graph 3 shows in 2016/17, children living in the most deprived wards in Hartlepool (naturally fluoridated) had a similar severity of dental decay as children living in the least deprived wards in Stockton-on-Tees (non fluoridated). In addition, fluoridation reduces the gap in disease severity within wards: for fluoridated Hartlepool the gap between the least deprived and most deprived wards was smaller than non- fluoridated Stockton-on-Tees. The improvements in oral health associated with fluoridation have been reported in the following report [Water fluoridation: health monitoring report for England 2022 - GOV.UK (www.gov.uk)]. Nationally, in the most deprived 20% of areas, the odds of experiencing caries was 25% lower in areas with a fluoridation scheme than in areas without. NENC benefits from both naturally fluoridated areas (Hartlepool and Easington) and artificial fluoridation schemes (parts of Northumberland, Tyneside, parts of County Durham and parts of North Cumbria).

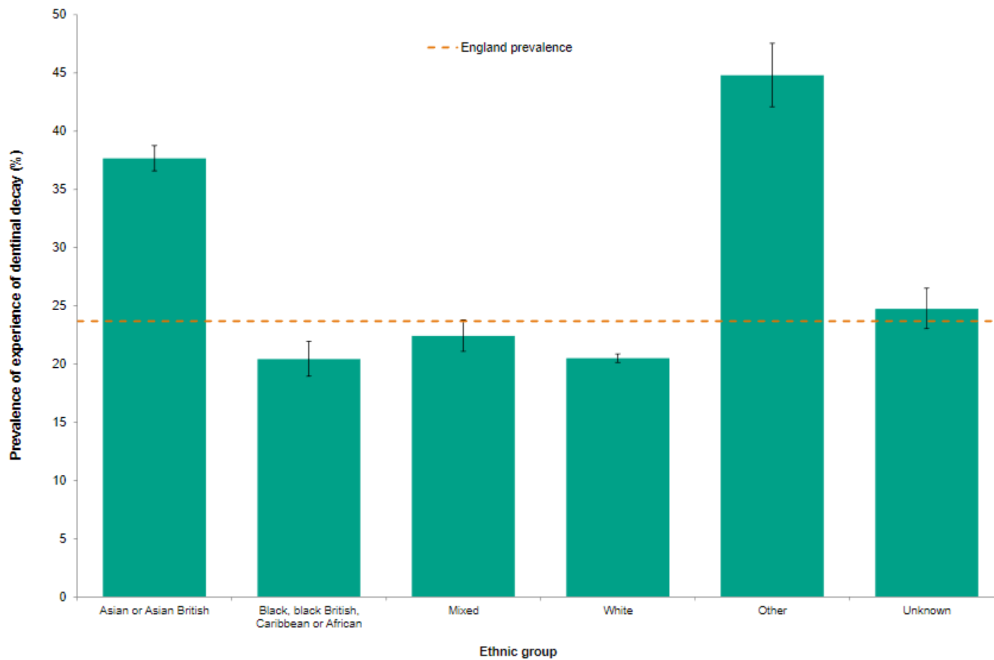
**Graph 3: Effects of water fluoridation on oral health in 2016/17 by levels of deprivation in Stockton-on-Tees and Hartlepool wards**



**Source:** Oral health - GOV.UK (www.gov.uk)

Ethnicity also has an effect on the oral health of 5-year-old children. The national 5-year-old-survey data set in 2022 (Graph 4) shows that children from Asian or Asian British (and the “other” category) backgrounds had worse oral health than their white or black/black British/Caribbean or African counterparts. Interestingly, these inequalities for Asian children in the deciduous dentition do not persist into the permanent dentition in 12- year-old children. Cultural factors, and infant feeding practices may play a role. There is no break down of the “other” category.

**Graph 4: Prevalence of decay in 5-year-olds in England by ethnic group, 2022**

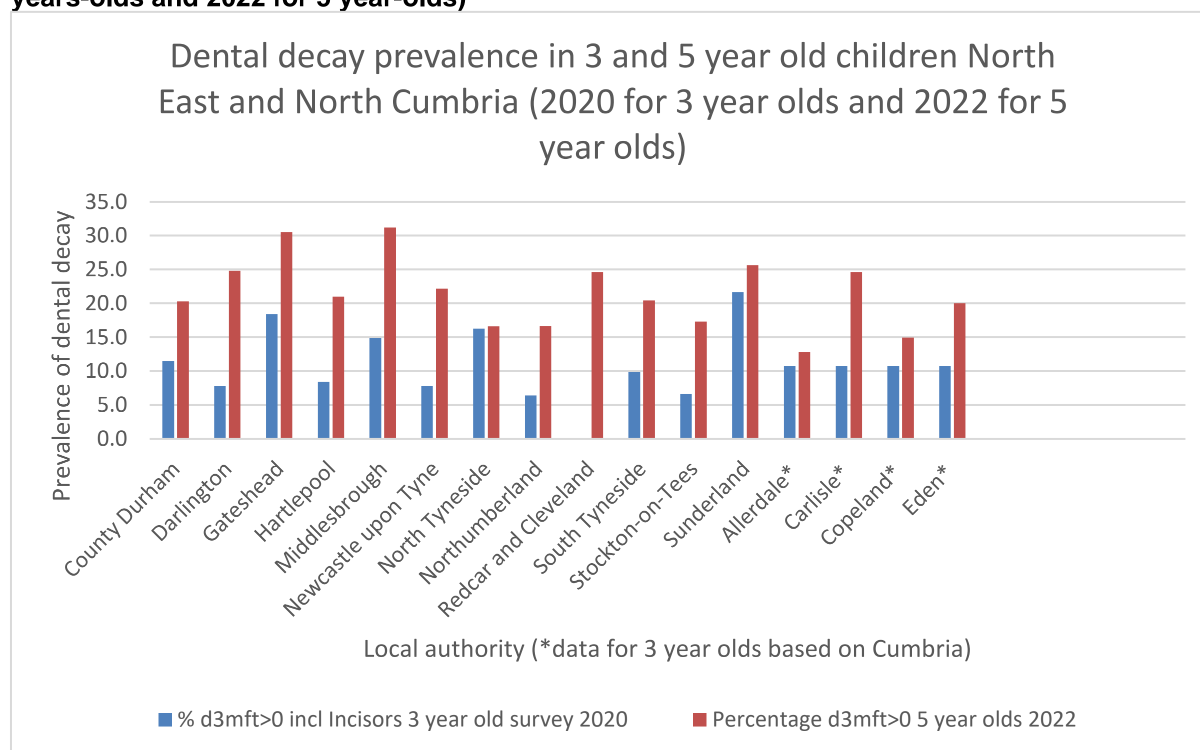



**Source:** Oral health - GOV.UK (www.gov.uk)

### Evidence for early intervention in young children (Issue 1)

There is a significant increase in dental decay prevalence from age 3 to age 5 in all areas in NENC. Graph 5, shows there is a doubling of decay from 3 to 5-year-olds in most local authority areas, from the most recent surveys undertaken in NENC in 2020 and 2022. The biggest increase in rates is in 3-year-olds (7%) to 5-year-olds (25%) in Darlington. This increase in rates of dental disease from age 3-5, can be explained by the aetiology of the decay process. It can take 18 months or more from the start of decay (enamel decay), to progress to a stage when a filling is required (dentinal decay). Early diagnosis (enamel decay) and treatment with fluoride, can reverse the early decay process. Encouraging dental attendance when teeth first come through into the mouth (Dental Check By One) can provide opportunities for prevention advice and fluoride intervention to reverse the effect of early decay. Optimising early fluoride interventions (fluoride varnish) within practices and supervised toothbrushing programmes in schools could reduce these significant increases in disease rates in very young children.

**Graph 5: Dental decay prevalence in 3 and 5-year-old children North East and North Cumbria (2020 for 3 years-olds and 2022 for 5 year-olds)**




**Source:** Oral health - GOV.UK (www.gov.uk)

**Oral health of adults and evidence of oral health inequalities (Issue 1)**

Levels of deprivation in adults have a marked effect on their oral health: the 2018 oral health survey of adults attending general practice reports 1 in 3 participants living in more deprived areas had untreated tooth decay compared to 1 in 5 in the less deprived areas. Poor oral health impacts daily living: including self-consciousness or embarrassment because of problems with teeth, mouth or dentures; difficulty eating any foods; and painful aching in the mouth. Adults in Middlesbrough (27.9%) Hartlepool (24.5%) and South Tyneside (25.8%) living in three of the most deprived local authority areas in the North East suffered more oral health impacts than the average for the North East (22.6%) or England (17.7%) (See Table 2).

There is significant variation in the oral health of adults attending NE and Cumbria dental practices. Notably, this variation does not seem to be linked to areas with lower Index of Multiple Deprivation (IMD) rankings (i.e. more deprivation). In fact, Table 2 shows adults in Northumberland (IMD= 116) had the highest levels of active decay in the whole of the North East (43.8% versus 27.3%), were three times more likely to present with an urgent treatment need (11.6% compared with 3.5%), and were most likely to require any treatment (84.8% compared to 75.4% in the NE). This variation in the level of treatment need does not appear to be linked with deprivation levels but can potentially have a substantial impact on the sustainability and profitability of practices providing NHS dental care in this area, as more clinical time will need to be dedicated to patients with a higher treatment need (practices receive the same payment to undertake 1 or 3 fillings). Any targeting of enhanced payments to address high needs patients needs to consider the oral health needs of the patients in Northumberland (and other high needs areas) and the effects on the sustainability of NHS dental practices. Deprivation as a population measure will not identify individual patient needs or groups of patients with high needs that are masked in generally wealthy areas.

**Table 2: Results of the adults in practice survey (2018) attending North East and Cumbria dental practices**

| Upper-Tier LA Name | % with active decay (DT>0) | Average number of decayed teeth (for those with active decay) | % with dentures | % with PUFA | % with any treatment need | % with an urgent treatment need | % suffering any oral health impacts fairly or very often | Local authority IMD ranking (2019) |
|---|---|---|---|---|---|---|---|---|
| England | 26.8 | 2.1 | 15.4 | 5.2 | 70.5 | 4.9 | 17.7 | |
| | | | | | | | | |
| North East | 27.3 | 2.2 | 18.6 | 5.3 | 75.4 | 3.5 | 22.6 | |
| County Durham | 26.8 | 1.8 | 16.9 | 2.8 | 84.5 | 7.2 | 17.6 | 62 |
| Darlington | 27.3 | 2.4 | 19.6 | 3.6 | 87.3 | 7.9 | 21.2 | 77 |
| Gateshead | 26.0 | 2.8 | 15.4 | 2.5 | 63.1 | 0.8 | 22.8 | 47 |
| Hartlepool | 25.9 | 3.0 | 11.8 | 3.2 | 80.0 | 2.4 | 24.5 | 10 |
| Middlesbrough | 28.5 | 2.9 | 20.7 | 10.7 | 75.7 | 3.4 | 27.9 | 5 |
| Newcastle upon Tyne | | | | | | | 11.8 | 41 |
| North Tyneside | | | | | | | | 111 |
| Northumberland | 43.8 | 1.8 | 22.3 | 1.8 | 84.8 | 11.6 | 13.6 | 116 |
| Redcar and Cleveland | 27.4 | 2.3 | 17.9 | 9.2 | 80.4 | 1.7 | 21.8 | 40 |
| South Tyneside | 18.6 | 1.8 | 19.6 | 6.8 | 47.9 | 0.5 | 25.8 | 27 |
| Stockton-on-Tees | 29.5 | 1.9 | 17.5 | 6.7 | 87.4 | 0.0 | 25.0 | 73 |
| Sunderland | 24.0 | 2.8 | 20.0 | 4.1 | 64.0 | 1.3 | 24.7 | 35 |
| Cumbria (No data for Eden) | 29.9 | 2.0 | 17.8 | 5.1 | 66.7 | 4.3 | 19.0 | No data |
| | | | | | | | | |
| England | 26.8 | 2.1 | 15.4 | 5.2 | 70.5 | 4.9 | 17.7 | |

Source: NDEP_for_England_OH_Survey_Adults_in_Practice_2018_Results.xlsx (live.com)

Dental attendance in adults can also affect the rates of untreated dental decay. In 2009, the adult dental health survey reported that adults (with teeth) that report never going to the dentist have more unmet need (43% have 1 or more decayed teeth) than regular attenders (14% have one or more decayed teeth). Those adults that attend only with trouble also have more primary dental decay (40%) compared to their regular attender counterparts (15%) (See Table 3). Therefore, it can be seen that patients who only attend irregularly or when in pain will have higher treatment needs. This will have implications for practices situated in deprived areas, that are taking on new patients, or offering a course of treatment to patients that attend initially in pain.

**Table 3: Extent of primary decay by reported dental attendance and behaviour of dentate adults**

*Dentate adults* — *England, Wales, Northern Ireland: 2009*

| Reported dental behaviour | | Number of teeth with primary caries: None | 1 | 2 | 3 or more | *Unweighted base* | *Weighted base (000s)* |
|---|---|---|---|---|---|---|---|
| **All** | % | 77 | 12 | 5 | 6 | *6,470* | *42,918* |
| **Dental attendance** | | | | | | | |
| Regular check up | % | 85 | 9 | 3 | 2 | *4,380* | *26,817* |
| Occasional check up | % | 75 | 13 | 6 | 7 | *550* | *4,278* |
| Only with trouble | % | 60 | 19 | 9 | 13 | *1,450* | *11,063* |
| Never goes to the dentist | % | 57 | 10 | 11 | 23 | *80* | *710* |

**Source: Adult Dental Health Survey 2009** Adult Dental Health Survey 2009 - Summary report and thematic series - NHS Digital

**Dental access for children and adults (Issue 2)**

Table 4 shows the percentage of adults and children accessing NHS dental care (2020-2022). Access to NHS primary dental care for children in March 2022 has not fully recovered to pre-pandemic levels. It is significantly lower (45.8%) than 2020 (61.1%) in the North East region and in Cumbria. This post-COVID recovery position is replicated for adults (39.1% compared to 56.2%). Although, the access rate recovery in the North East for adults (39.1%) is higher than the England average (34.1%), Cumbria (30.6%) and County Durham (33.8%) are exceptions to this and may reflect the lower levels of NHS dental activity delivered presented in Table 10.

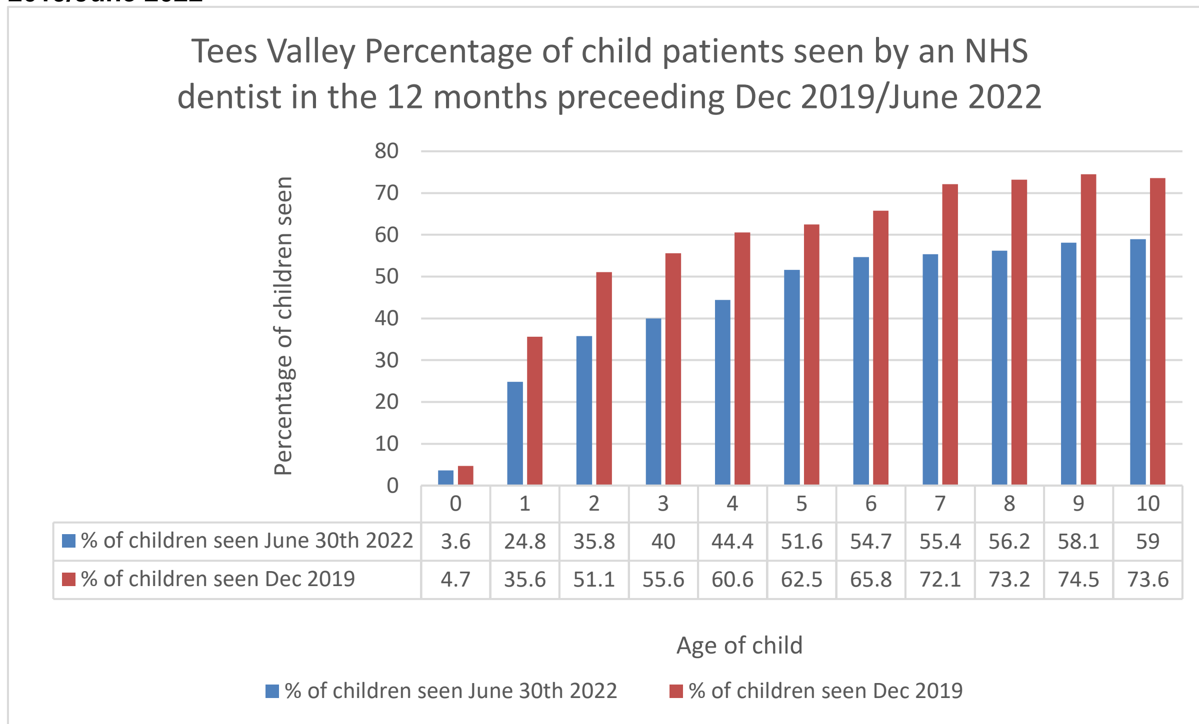
**Table 4 Percentage of children and adults accessing NHS primary dental care**

| Area | Percentage of children (0-17y) accessing dental care in 12 months before: | | | Percentage of adults (18y+) accessing dental care in 24 months before: | | |
|---|---|---|---|---|---|---|
| | 31 March 2020 | 31 March 2021 | 31 March 2022 | 31 March 2020 | 31 March 2021 | 31 March 2022 |
| England | 58.3% | 23.1% | 45.4% | 49.3% | 43.1% | 34.6% |
| North East Region | 61.1% | 21.6% | 45.8% | 56.2% | 48.7% | 39.1% |
| North ICP | 63.4% | 22.7% | 47.4% | 56.2% | 48.7% | 38.9% |
| Gateshead | 64.9% | 21.9% | 49.2% | 57.8% | 50.6% | 41.2% |
| Newcastle | 65.0% | 24.7% | 48.6% | 57.4% | 48.0% | 39.3% |
| North Tyneside | 60.1% | 19.2% | 45.0% | 55.0% | 47.5% | 37.3% |
| Northumberland | 63.1% | 23.5% | 46.6% | 54.8% | 49.0% | 38.3% |
| Central ICP | 57.6% | 18.2% | 41.9% | 55.1% | 47.0% | 37.6% |
| County Durham | 54.0% | 17.6% | 40.7% | 50.5% | 42.5% | 33.8% |
| Sunderland | 61.6% | 18.5% | 43.0% | 59.3% | 51.3% | 40.7% |
| South Tyneside | 62.9% | 19.8% | 44.2% | 63.8% | 55.0% | 45.5% |
| Tees Valley ICP | 63.0% | 22.8% | 48.4% | 57.7% | 50.9% | 41.3% |
| Darlington | 64.0% | 26.5% | 44.6% | 56.6% | 49.6% | 38.8% |
| Hartlepool | 54.2% | 18.6% | 42.9% | 51.6% | 45.6% | 38.6% |
| Middlesbrough | 67.8% | 20.5% | 48.5% | 63.4% | 53.6% | 39.9% |
| Redcar and Cleveland | 61.9% | 20.9% | 47.0% | 61.1% | 53.9% | 45.1% |
| Stockton-on-Tees | 63.6% | 25.9% | 53.6% | 54.8% | 50.0% | 42.3% |
| Cumbria | 60.6% | 27.0% | 48.3% | 46.6% | 39.8% | 30.6% |

**Source: NHS Digital, 2022**

Recovery of access rates for very young children (2-year-olds) are particularly low at only 35.8% in June 2022 (Tees Valley given as an example) compared to rates pre-pandemic (51.1%). Low dental attendance rates result in missed early intervention opportunities to give prevention advice and start fluoride applications for high risk children. Graph 6 shows the rates of attendance of Tees Valley children aged 1-10 years, between the ages of 1 and 5 there is a 100% increase (24.8% increased to 51.6 %) in dental attendance, however, for many children attending for the first time at age five is too late, decay has already started. More needs to be done to promote the national campaign “Dental check by one” to raise dental attendance rates at the earliest possible opportunity.

**Graph 6: Tees Valley Percentage of child patients seen by an NHS dentist in the 12 months preceding Dec 2019/June 2022**




| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| % of children seen June 30th 2022 | 3.6 | 24.8 | 35.8 | 40 | 44.4 | 51.6 | 54.7 | 55.4 | 56.2 | 58.1 | 59 |
| % of children seen Dec 2019 | 4.7 | 35.6 | 51.1 | 55.6 | 60.6 | 62.5 | 65.8 | 72.1 | 73.2 | 74.5 | 73.6 |

**Source: NHS Digital, 2022**

### Dental Access Need for Children in Care (Issue 2)

Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. Oral health is one of the five clinical areas of focus which require accelerated improvement. The dental metrics has put a focus on Children in Our Care (CIOC).

A Tees Valley dental access referral pathway for CIOC and those children receiving child protection referrals was launched in 2023 to address the inequalities in access to dental care identified in Table 5. Stockton-on-Tees LA (57%) and Hartlepool LA (29%) have the highest rates of CICO not accessing statutory annual dental checks. In other areas of the ICB, other referral pathways exist for CIOC.

**Table 5: Children in our Care across Tees Valley not receiving an annual dental assessment in 2021**

| Local Authority | Percentage of CIOC not receiving an annual Dental Check | Numbers of CIOC not receiving an annual Dental Check | Eligible Cohort |
|---|---|---|---|
| Stockton-on Tees | 57% | 253 | 445 |
| Hartlepool | 29% | 73 | 254 |
| Redcar | 12% | 27 | 231 |
| Darlington | 11% | 21 | 190 |
| Middlesbrough | 19% | 70 | 370 |
| Tees Average | 25% | 444 | 1490 |

**Source: Local Authority provided data**

### Dental Access for New Patients (Issue 2)

The GP survey undertaken Jan-March 2022 reported that 83% of NENC patients were successful in getting an appointment in the last 3 months if they had been there before, however, only 43% were successful if they had not been there before. This provides the evidence that new patient access can be challenging, and commissioning needs to incentivise new patient access. Table 6 reports the findings of the GP Survey.

**Table 6 GP survey January - March 2022**

| | Last time you tried to get an NHS dental appointment, was it with a dental practice you have been to before for NHS dental care? | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Region /ICS name | Yes, been there before | | | | | | | | No, not been there before | | | | | | |
| | Success in getting appointment | | | | | | | | | | | | | | |
| | Total responses (weighted)[2,3] | % Yes | % No, no appointment available | % No, dentist not taking new patients | % No, other reason | % Total No | % Can't remember | | Total responses (weighted)[2,3] | % Yes | % No, no appointment available | % No, dentist not taking new patients | % No, other reason | % Total No | % Can't remember |
| England | 292,594 | 82% | 10% | 3% | 5% | 17% | 1% | | 47,451 | 31% | 19% | 37% | 8% | 64% | 4% |
| NEY | 48167 | 83% | 9% | 2% | 5% | 16% | 1% | | 6,586 | 32% | 19% | 37% | 8% | 64% | 4% |
| NENC ICS | 17,365 | 83% | 9% | 2% | 4% | 16% | 1% | | 2,027 | 43% | 17% | 29% | 7% | 53% | 3% |

**Source**: Statistics » GP Patient Survey Dental Statistics; January to March 2022, England

### Access to General Anaesthetic Services for Children (Issue 3)

Equitable access to general anaesthetic services and reducing waiting lists and waiting times is another CORE20PLUS5 dental metric. Tooth decay is the most common reason for hospital admissions in the 6-10-year-old age group. During COVID, the loss of services had a dramatic impact on waiting times and waiting lists in some areas of NENC. NUTH in June 2023 (Table 7) is reporting 709 children waiting to be seen for treatment with a further 237 waiting for assessment. The average treatment waiting time is 78 weeks. NCIC is also reporting only 50% recovery and the longest wait of 71 weeks. Poor access to general anaesthetic services increases pain and suffering for young children, the number of recurrent infections they experience, and increases in antibiotics prescriptions required to manage dental infections.

**Table 7: Waiting lists (WL) and Waiting Times (WT) (June 2023 Local Provider Data)**

| Trust | WL: Number of patients waiting for GA assessment | WL: Number of patients waiting for GA treatment | WT: Assessment Appointment | WT: Treatment Appointment | WT: Longest Wait | Recovery Percentage |
|---|---|---|---|---|---|---|
| NTH FT | Not recorded | 54 | 4 weeks | 14 weeks | 17 weeks | 100% |
| CDDFT | Not recorded | 168 | Not recorded | 28 weeks | 29 weeks | 100% |
| SOTW | Not recorded | 165 | 10 weeks | 12 weeks | 51 weeks | 100% |
| NUTH | 237 | 709 | 17 weeks | 78 weeks | 78 weeks | 100% |
| Northumbria FT | Not recorded | 93 | 11 weeks | 14 weeks | 20 weeks | 100% |
| NCIC | 77 | 125 | 10 weeks | 20 weeks | 71 weeks | 50% |

**Oral Health of Older People (Issue 4)**

The PHE Report "What is known about the oral health of older people" reported the following:

- Untreated tooth decay is higher in the household resident elderly population than in the general adult population. Older adults living in care homes have an even higher decay prevalence, with the majority of dentate residents having active decay.
- Care home managers experience much more difficulty in accessing dental care for their residents than older adults living in their own homes.
- For older adults living in care homes, dental services are patchy and often no regular or urgent dental care arrangements exist for the provision of domiciliary care.
- Approximately half of residents in care homes would find it difficult or impossible to receive urgent treatment in a general dental practice due to medical or psychological complications.
- Little is known about access to services for the increasing numbers and proportions of older people receiving 'care in your home' services.
- Oral health assessments and staff training focus mostly on the presence of teeth and dentures, and oral hygiene or denture cleaning skills. Training on the recognition of urgent problems in residents and how to access urgent or emergency dental care was less common.

Prevention of dental decay in this vulnerable group of adults is paramount, not least because access to dental care is more difficult but also managing care in these patients with poly pharmacy is challenging and could need specialist skills of special care dentistry. Any regular fluoride interventions i.e. the prescription of higher strength fluoride toothpaste and at least twice yearly fluoride varnish applications could mitigate the risk of new dental decay in this group. Training for care home staff in providing regular mouth care for those residents that are unable to self-care is also crucial. Table 8: shows 61% care home residents in the North East have poor oral hygiene, a significant number (43%) are brushing either once or less than once a day. The contrasting brushing habits between care home residents and adults in the 2009 ADHS is stark: 75% of adults brush twice a day in comparison with only 43% care home residents. These results would suggest that many residents would benefit from support in brushing their teeth.

**Table 8: Oral hygiene status of residents in North East care homes 2013**

| Oral hygiene status of residents in North East care homes 2013 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Cluster** [N = number of residents] | **Oral hygiene** [Number and (%)] | | **Reported frequency of brushing** [Number and (%)] | | | **Residents cleaning own teeth** [Number and (%)] | **Clinician identified oral hygiene instruction needed** [Number and (%)] |
| | **Good** | **Poor** | **Less than once a day** | **Once a day** | **Twice or more a day** | | |
| **North East** N= 312 | **99 (32%)** | **191 (61%)** | **51 (16%)** | **84 (27%)** | **135 (43%)** | **245 (79%)** | **176 (56%)** |
| **ADHS*** | **34%** | **66%** | **3%** | **22%** | **75%** | | **N/A** |
| *Adult Dental Health Survey (2009) Source Local epidemiology data 2013 (unpublished) | | | | | | | |

**Oral Cancer (Issue 5)**

Oral cancer, also known as mouth cancer, is an important public health issue in England. Oral cancer includes cancers of all sites of the oral cavity and pharynx and is the sixth most common cancer globally. In the UK, oral cancer is the ninth most common cancer and accounts for just over 2% of all cancers diagnosed.

Known risk factors for oral cancer are linked to wider social determinants and include: smoking; other ways of using tobacco such as chewing; drinking alcohol; and infection with the human papilloma virus (HPV). Tobacco and alcohol act synergistically and multiply the risk of developing mouth cancer by up to 40%. Smokers are 7-10 times more likely to suffer from an oral cancer when compared to those who have never smoked. In addition, those who regularly use smokeless tobacco have over 11 times the risk of a non-user. There is some evidence that a poor diet is also a risk factor for oral cancer, with some evidence stating the protective role of fruits and vegetables, particularly citrus fruits, in the prevention of the development of cancers of the digestive and upper respiratory tract. Awareness of these risk factors provides opportunities in the prevention of oral cancer, and to support early detection and treatment.

Oral cancer disproportionately affects males and its incidence and mortality increase with age and deprivation. The reasons for these increases are poorly understood but may be partially explained by trends in risk factors and latency period, as well as stage at presentation. The incidence of oral cancer is known to vary by ethnicity.

For NENC at a local authority level, Newcastle, South Tyneside, Sunderland, and Stockton-on-Tees were all found to be statistically significantly above the England average for incidence. Sunderland and Stockton-on-Tees were also statistically significantly above the England average for mortality. Eden was the only local authority area in NENC found to be statistically significantly lower than the England average for incidence of C00-C14 (Table 9).

Partnership working across the totality of primary care and the health and social care system, could maximise the skills of the wider health and social care workforce and help reduce risks by making every contact count. Dental practices signposting patients to: stop smoking services; drug and alcohol misuse services; and the HPV vaccination could also contribute to reducing incidence of the disease.

**Table 9: Standardised incidence and mortality of C00-C14 by area, 2012 to 2016**

| Area | Standardised incidence per 100,000 | Lower 95% CI | Upper 95% CI | Standardised mortality per 100,000 | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|---|
| England | 14.55 | 14.40 | 14.71 | 4.54 | 4.45 | 4.62 |
| NHS North East and North Cumbria | - | - | - | - | - | - |
| North East Region | 16.88 | 16.15 | 17.62 | 5.45 | 5.02 | 5.88 |
| North ICP | - | - | - | - | - | - |
| Gateshead | 15.96 | 13.29 | 18.63 | 4.06 | 2.61 | 5.51 |
| Newcastle | 21.05 | 18.19 | 23.91 | 6.08 | 4.45 | 7.71 |
| North Tyneside | 15.06 | 12.46 | 17.66 | 4.38 | 2.86 | 5.89 |
| Northumberland | 15.30 | 13.37 | 17.24 | 4.74 | 3.62 | 5.87 |
| Central ICP | - | - | - | - | - | - |
| County Durham | 15.83 | 14.22 | 17.43 | 5.38 | 4.39 | 6.38 |
| Sunderland | 18.57 | 16.10 | 21.05 | 6.44 | 4.81 | 8.08 |
| South Tyneside | 22.50 | 18.84 | 26.16 | 5.83 | 3.84 | 7.82 |
| Tees Valley ICP | - | - | - | - | - | - |
| Darlington | 14.93 | 11.26 | 18.60 | 7.10 | 4.49 | 9.72 |
| Hartlepool | 14.56 | 10.56 | 18.55 | 6.86 | 3.84 | 9.89 |
| Middlesbrough | 16.87 | 13.13 | 20.60 | 4.35 | 2.25 | 6.45 |

| Redcar and Cleveland | 14.48 | 11.43 | 17.54 | 4.59 | 2.72 | 6.47 |
|---|---|---|---|---|---|---|
| Stockton-on-Tees | 18.43 | 15.42 | 21.45 | 7.35 | 5.32 | 9.39 |
| North Cumbria ICP | - | - | - | - | - | - |
| Carlisle | 18.16 | 14.31 | 22.01 | 4.97 | 2.83 | 7.12 |
| Eden | 10.26 | 6.12 | 14.40 | NA | | |
| Allerdale | 14.61 | 11.03 | 18.19 | 4.49 | 2.27 | 6.70 |
| Copeland | 14.05 | 9.46 | 18.64 | 5.58 | 2.44 | 8.72 |

**Source: Oral cancer in England A report on incidence, survival and mortality rates of oral cancer in England, 2012 to 2016**

**Commissioning of primary care services (Issues 6, 7 and 8)**

Primary care services are in the main equitably commissioned across the NENC, however there are a few exceptions. Table 10 shows the commissioned activity and services per head of population. It can be seen residents of North Cumbria (2021/2022) have the lowest UDAs commissioned per head of population at 1.46. and County Durham is the 2$^{nd}$ lowest with 1.58. Commissioning levels are predominately based on historical contracts in place in 2006. Prior to the introduction of local commissioning dental service provision was primarily determined by provider choice.

Interestingly, Table 10, also shows that commissioned activity is not the same as delivered activity which more accurately reflects access to services for new and existing patients. North Cumbria has the lowest level of delivered UDAs per head of population, followed by County Durham at 1.02, these lower than expected delivery rates may affect patient access (See table 4). Fortunately, delivery rates are the highest in the most deprived local authority areas of Middlesbrough (1.30) and Hartlepool (1.37) who have the highest proportions of their populations in the top 10% of most deprived communities nationally.

Workforce shortages will undoubtedly have had an impact on delivery of dental activity and underperformance within current contracts. A local workforce survey undertaken in September 2022, (200 responses) reported 62% of dental practices had long term dentist vacancies they were struggling to fill, with 41% also indicating they had wider clinical team workforce vacancies e.g. dental nurses. Currently, 77% of contracts across NENC are identified with concerning performance at below 80% expected activity. This in turn affects the availability of routine dental care to the population, access for high needs new patients, and availability of unscheduled/urgent care for patients in pain.

Contract hand backs in 2023 have been accelerating at a rate not experienced before in the NENC. So far in 2023 (up to May), there have been 14 confirmed contract hand backs, with this trend continuing. North Cumbria, North Northumberland, Durham and Darlington have all been particularly affected.

**Table 10 UDAs commissioned and delivered per head of population**

| | 2019/2020 (Pre-COVID) | | | 2020/21 (During COVID) | | | | 2021/2022 (Post-COVID) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Locality | UDAs Commissioned | UDAs Commissioned per Head of Population | UDAs Delivered per Head of Population | UDAs Commissioned | UDAs Commissioned per Head of Population | UDAs Delivered 20/21 | UDAs Delivered per Head of Population | UDAs Commissioned | UDAs Commissioned per Head of Population | UDAs Delivered 21/22 *Does not inc local 1.8 Top Up Scheme* | UDAs Delivered per Head of Population |
| **Sunderland** | 526,065 | 1.92 | 1.77 | 540,690 | 1.97 | 142,004 | 0.52 | 538,719 | 1.96 | 337,454 | 1.23 |
| **South Tyneside** | 334,686 | 2.26 | 1.97 | 336,316 | 2.28 | 85,870 | 0.58 | 335,793 | 2.27 | 217,734 | 1.47 |
| **Gateshead** | 364,347 | 1.86 | 1.82 | 364,195 | 1.86 | 97,869 | 0.50 | 364,366 | 1.86 | 249,321 | 1.27 |
| **Newcastle** | 537,887 | 1.79 | 1.63 | 539,525 | 1.80 | 149,951 | 0.50 | 536,167 | 1.79 | 353,901 | 1.18 |
| **Northumberland** | 568,070 | 1.77 | 1.61 | 584,849 | 1.82 | 136,216 | 0.42 | 582,618 | 1.82 | 382,136 | 1.19 |
| **North Tyneside** | 377,050 | 1.80 | 1.66 | 377,861 | 1.81 | 93,019 | 0.45 | 378,082 | 1.81 | 240,773 | 1.15 |
| **North Cumbria** | 505,582 | 1.54 | 1.22 | 496,450 | 1.51 | 129,245 | 0.39 | 479,544 | 1.46 | 252,075 | 0.77 |
| **County Durham** | 819,106 | 1.57 | 1.39 | 821,415 | 1.57 | 204,345 | 0.39 | 824,184 | 1.58 | 534,548 | 1.02 |
| **Darlington** | 200,668 | 1.86 | 1.64 | 191,852 | 1.78 | 55,060 | 0.51 | 191,873 | 1.78 | 119,067 | 1.10 |
| **Redcar and Cleveland** | 285,891 | 2.09 | 1.86 | 280,540 | 2.06 | 71,807 | 0.53 | 285,064 | 2.09 | 198,368 | 1.45 |
| **Hartlepool** | 175,527 | 1.90 | 1.73 | 190,485 | 2.06 | 50,296 | 0.54 | 191,367 | 2.07 | 126,484 | 1.37 |
| **North Tees** | 348,774 | 1.77 | 1.69 | 367,994 | 1.87 | 101,963 | 0.52 | 371,994 | 1.89 | 251,194 | 1.28 |
| **Middlesbrough** | 302,385 | 2.10 | 1.83 | 299,662 | 2.08 | 68,971 | 0.48 | 301,316 | 2.09 | 187,490 | 1.30 |
| **NE and NC Overall** | 5,346,038 | 1.80 | 1.61 | 5,391,834 | 1.81 | 1,386,616 | 0.47 | 5,381,087 | 1.81 | 3,450,545 | 1.16 |

Source: NENC local commissioning team

## 4. Which population groups are at risk and why?

This section reports how risk factors such as age, gender, ethnicity, and lifestyle can affect oral health. It also highlights certain population groups with higher disease rates compared to the average population.

This is about who is at risk of developing dental disease **not** the outcomes and risks of people who already have dental disease.

| | |
|---|---|
| **Age** | Young children living in deprived areas have higher rates of dental decay compared to their counterparts living in the least deprived areas. Low incomes, high sugar consumption, and suboptimal fluoride exposure are all contributory risk factors.<br>Older people may have difficulty brushing their teeth and may rely on others to maintain their oral health regime.<br>Older people may find traveling to a dental practice more difficult.<br>Co-morbidities e.g. Parkinson's, dementia, drugs that lead to dry mouth make the effects of oral diseases worse. Adults living with dementia will experience difficulties in maintaining good oral hygiene. |
| **Gender** | Middle-aged males who smoke and drink more than the recommended safe levels are at greater risk of oral cancer. Rates of Human Papilloma Virus (HPV16) associated oral cancer incidence are increasing in younger females. |
| **Socioeconomic status** | Health inequality is a common feature in dental disease; high levels of dental disease tend to affect those in low income families and those living in socially deprived conditions.<br>Children from low socioeconomic groups or living in deprived areas have worse oral health. |
| **Diabetes** | People with diabetes are more prone to gum disease and premature loss of teeth. |
| **Mental health** | Adults living with dementia may experience difficulties in maintaining good oral health. |
| **Ethnicity** | Asylum seekers and eastern European communities have poorer oral health compared to the general population. |
| **Prisoners** | Periodontal disease and dental decay levels in the prison population are around 4 times higher than the general population. |
| **Drug Misuse** | Drug misusers taking methadone with sugar are at a higher risk of dental decay due to the increased frequency of sugar intake associated with methadone rehabilitation therapy. Also a more chaotic lifestyle is likely to result in a diet which is high in sugar.<br>Drug users generally have a neglected dentition. |
| **People with learning disabilities** | Surveys of the dental health of adults with learning disabilities show that poor oral hygiene and a high prevalence of gum disease are common. |
| **Homeless** | Evidence suggests that homeless people experience significant levels of health inequalities, including poorer dental health and higher levels of dental decay and periodontal disease than the general population. High incidences of smoking and alcohol consumption put homeless populations at a higher risk of developing oral cancer. There is a high incidence of cancers of the mouth amongst homeless men. |
| **Migrants, asylum seekers, resettled refugees, and Gypsy, Roma, Traveller community** | Studies have indicated a high prevalence of oral disease and unmet oral healthcare needs in refugees, often exceeding the levels experienced by the most disadvantaged communities of the host country. Most commonly, refugees experience high levels of dental caries, periodontal disease, oral lesions, and traumatic dental injuries. |

## 5. Consultation and engagement

This section summarises what the public or dental practices have told us about services and access to services.

| Issue number | Strategic Issue |
|---|---|
| 1 | A local NHS England engagement event for dental practices (Jan 2019) identified that more needs to be done to encourage the provision of prevention in primary dental care. Suggestions were made regarding the commissioning of oral health promotion programmes from dental practices to promote community engagement and closer working between dental practices, schools and Health Visitors. |
| 1 | Feedback from school staff and parents in schools that have implemented toothbrushing programmes report that children really enjoy brushing their teeth in school and that this has made a positive difference to the home toothbrushing routine. Parents who had found difficulties in getting their children to brush at home were now finding this an enjoyable experience. |
| 2 | The GP survey undertaken Jan-March 2022 reported that 83% of NENC patients were successful in getting an appointment in the last 3 months if they had been there before, however, only 43% were successful if they had not been there before. This provides the evidence that new patient access can be challenging, and commissioning needs to incentivise new patient access.<br><br>Statistics » GP Patient Survey Dental Statistics; January to March 2022, England<br><br>The North East and North Cumbria Health Watch Networks report Experiences of dental care services March 2020-January 2022 reported: there was an even split in patients finding it difficult or very difficult to get a routine appointment/appointment for minor issues/urgent issues or finding it easy or very easy to get an appointment.<br><br>Regional Healthwatch Dentistry Consultation Report 2022.pdf (healthwatchdarlington.co.uk) |
| 4 | Qualitative research on older people and their preferences around oral health suggests that maintaining oral health is an important component of older people's sense of autonomy, self-control and self-worth. Patient-centred research found the following factors to be important to them: being able to function, being pain free and maintaining self-respect and dignity. |
| 8 | A local workforce survey undertaken in September 2022, reported 62% of dental practices had long term dentist vacancies they were struggling to fill, with 41% also indicating they had wider clinical team workforce vacancies e.g. dental nurses. These vacancies were affecting delivery of patient care. |

## 6. What is being done and why?

This section describes what is currently being done to address the strategic issues identified in Table 1

**Commissioning initiatives to reduce inequalities and ensure equitable access (Issue 1, 2, 6 7 and 8)**

The dental incentivised access scheme to supplement additional capacity has been offered to all dental practices in the NENC. The aim of the access scheme is to improve access for vulnerable groups and treat new patients with high needs. The spread of uptake has been broadly consistent across all NENC areas with the exception of North Cumbria where only 2 practices have engaged with the scheme in 2022-23. Extreme workforce challenges and access demands require further consideration and action to identify local NHS dental access solutions.

Recruitment and retention initiatives such as the golden hello scheme are being offered to targeted areas where contracts have been handed back and access challenges have been identified. Areas such as North Cumbria, North Northumberland, Durham and Darlington. Foundation dental practices are being prioritised and supported in areas of greatest need and workforce shortages, in the hope that new dentists will choose to stay in the area and bolster the local NHS workforce.

Struggling North Cumbria practices have been offered short term financial support packages to retain NHS sustainability. Local re- commissioning of handed back activity has been offered to existing dental practices via an open expression of interest. This has allowed for quicker re- commissioning of lost activity and failing this, still allows for formal procurements which are being planned.

The 'Dental Check by One' (DCby1) initiative was launched in 2017 by the British Society of Paediatric Dentistry (BSPD) in partnership with the Office of the Chief Dental Officer for England. The aim of this campaign was to ensure that all babies are seen by a dentist as soon as their first teeth come through, or by their first birthday at the latest. Dental practices are encouraged to support this campaign.

Implementation of the Tees Valley dental access referral pilot for Children In Our Care (CIOC) and those receiving children protection medicals was implemented in January 2023. This pilot is currently being evaluated. Early findings from referring clinicians have indicated that a 100% would like the scheme to continue and be extended to other health and social care workers to make referrals for vulnerable children on child protection plans.

**Commissioning prevention activity to improve oral health in children (Issue1)**

Commissioning of clinical prevention from dental practices is part of mandatory services and commissioned from all dental practices. However, the current contractual arrangements do not incentivise or indeed facilitate the provision of prevention activity. In 2017 NHS England did launch Starting Well: A Smile4Life Initiative. This programme of dental practice-based initiatives aimed to reduce oral health inequalities and improve oral health in children under the age of five years. The programme was available to all children, with a focus on those who were not currently visiting the dentist and under one-year-olds. It aimed to ensure that evidence-based preventive advice about reducing sugar intake and increasing the exposure to fluoride on teeth was given to parents of these children. This was a short term initiative only offered to Middlesbrough practices which has now ended.

School based supervised toothbrushing programmes recommended by NICE and PHE as effective prevention programmes to improve oral health have been commissioned in Teesside since 2008. Darlington and Durham Local Authorities have also paid for toothpaste and toothbrush resources for these programmes in recent years and are planning programme extensions. Local Authorities are under financial pressures which have limited the scope of the programmes in Durham and worryingly Darlington LA have not identified funding for 2023/24. These prevention programmes are an exemplar of systems working together: NHS England commissioning the dental workforce (as part of the CDS services) and the LAs providing the funding for resources. The following LAs in NENC have not invested in supervised toothbrushing schemes: South Tyneside, Gateshead, Newcastle, North Tyneside, Northumberland, North Cumbria.

School Fluoride Varnish Programmes had been commissioned by LAs in South Tees and Stockton -on-Tees. However, during COVID these contracts lapsed. The targeted programme is delivered by dental practices commissioned by the public health local authority team, and pupils receive 2 cycles of fluoride varnish per school year. Schools in this programme have been targeted based on high dental decay rates. Commissioning of fluoride varnish programmes are recommended by NICE and PHE to improve oral health in high-risk children.

**Commissioning of Additional General Anaesthetic Services (Issue 3)**
Non recurrent funding has been offered in 2022/2023 to Community Dental Service (CDS) services to reduce the back-log of general anaesthetic waiting lists and numbers. However, there was limited uptake as CDS services struggled to secure theatre capacity and/or anaesthetic/ paediatric teams to undertake the additional sessions.

**Commissioning of prevention programmes in residential care homes (Issue 4)**

The "Caring 4 your Smile" is a North East oral health promotion programme delivered in care homes by the Tees/ County Durham and Darlington Oral Health Promotion programmes commissioned by NHS England. In 2023, the Care Quality Commission (CQC), published a review of action taken across systems to implement their original six recommendations Smiling matters: oral health in care homes- progress. This document highlighted as a case study the work that had been undertaken in the North East to implement both NICE guidelines (NG48) and CQC recommendations for care homes.

As part of this programme, training is provided to carers on maintaining daily mouth care for residents, and information on how to access NHS dental services both routine and urgent.

## 7. What needs are unmet?

This section provides details of what needs are being unmet from section 3 and 6. If needs are being addressed these are not considered in this section.

| Issue number | Unmet need |
|---|---|
| 1 | Children (5-year-ols) in Middlesbrough and Gateshead have higher levels of dental decay than the England average. Optimising evidence based prevention interventions at an early stage would mitigate these risks. Dental decay is entirely preventable. |
| 2 | Access to NHS primary dental care for children in March 2022 is significantly lower (45.8%) than prior to the pandemic in 2020 (61.1%) in all areas of the NENC. This position is replicated for adults (39.1% compared to 56.2%). The access rate recovery in the North East for adults is higher than the England average (34.1%), however, Cumbria (30.6%) and County Durham (33.8%) are exceptions to this.<br><br>Adults not accessing regular care find it harder to access care as a new patient or when in pain. Some practices do not have the capacity to take on new patients, whilst financial considerations make it unviable for others.<br><br>Uptake of dental care in very young children is sub optimal with only 25% of one-year-old children in Tees Valley (as an example) attending for a check-up and prevention advice and intervention. As dental decay can start from the age of one (when teeth first appear in the mouth) it is essential that children access prevention care and have optimal fluoride exposure at the earliest possible opportunity: 75% of children have an unmet need. Currently there are mixed messages across the healthcare system re attendance by the age of one, with some dental practices reluctant to take-on young children. |
| 3 | Children in Newcastle and North Cumbria are waiting too long for routine extractions under general anaesthesia. NUTH has the longest waiting lists numbers (709) and times (78 weeks) which are significantly higher than all other Trusts in NENC.<br><br>North Cumbria Integrated Care (NCIC) Trust are also reporting only 50% recovery in elective care and have a longest wait of 71 weeks.<br><br>The untreated dental decay and associated morbidity is not being addressed in a timely way. |
| 4 | Access to prevention, routine and urgent care for care home residents may not be meeting need. However, lack of local data makes it difficult to establish the true level of unmet need.<br><br>Local data on poor oral hygiene practices suggests that there are unmet mouth care needs in residents in these settings. |
| 5 | Adults in Newcastle, South Tyneside, Sunderland, and Stockton-on-Tees were all found to be significantly above the England average for oral cancer incidence. Adults in Sunderland and Stockton-on-Tees were also significantly above the England average for mortality. Late presentation is generally responsible for poor outcomes but it is unclear how to address these unmet needs particularly in middle-aged men with higher risk factors. |

## 8. What needs to be done and why?

This section provides recommendations for commissioners in relation to gaps in service provision and to propose new measures/build on existing work to address unmet need.

| Issue number | What needs to be done? |
| --- | --- |
| **Address oral health inequalities (Issue1)** | Optimise prevention opportunities both in primary care dental settings and evidence-based community level prevention programmes. E.g. supervised toothbrushing and fluoride varnish programmes.<br><br>Target community prevention programmes to early years age groups<br>Commission equitable access to dental care in areas of social deprivation.<br><br>Ensure practices in the 20% most deprived populations (In line with deep end methodology) are incentivised to take on new patients with potentially higher dental needs.<br><br>Northumberland dental practices need to be considered for any incentive schemes in addition to areas of identified deprivation as the higher level of dental treatment need identified is not consistent with deprivation levels.<br><br>Support extension of water fluoridation schemes in the North East to reduce inequalities in dental decay. |
| **Address dental access issues (Issue 2)** | Continue with short term initiatives to re-commission lost activity from existing practices and sessional activity focused on vulnerable groups and patients in pain.<br>Re launch Dental Check By One (DCby1) campaign with local practices and Health Visitors to encourage parents to take children to the dentist as soon as they get their first teeth.<br><br>Ensure all practices but particularly practices with the 20% most deprived populations (In line with deep end methodology) are incentivised to take on young children and deliver prevention in line with Delivering Better Oral Health guidance. |
| **Address long waiting lists and waiting times for routine extractions under GA (Issue 3)** | Secondary care commissioners to work with NUTH to commission waiting list initiatives and secure theatre capacity to reduce waiting lists and waiting times.<br><br>Mutual aide by Trusts to collaboratively secure general anaesthetic care closer to home particularly for children not residing in Newcastle that do not have complex medical needs.<br><br>Operational Delivery Network (ODN) work with North Cumbria to highlight long waiters that are not recorded in CIC Trust systems and therefore not visible. |

| | |
|---|---|
| | Paediatric MCN to identify pathway and theatre optimisation opportunities in line with GIRFT recommendations for elective recovery. |
| **Address the unmet needs of older adults in residential care homes (Issue 4)** | Ensure all residential care homes are aware of the commissioned dental services available for urgent and routine dental care.<br><br>Ensure commissioned special care dentistry services are available for this vulnerable group.<br><br>Collaborate with ICPs to extend the Caring 4 your Smile programme in residential settings within NENC<br><br>Evaluate the pilot fluoride varnish programme in SOTW residential care settings.<br><br>Monitor waiting times for access to domiciliary care. |
| **Address high incidence and mortality associated with oral cancer (Issue 5)** | Identify and sign-post individuals that would benefit from stop smoking interventions.<br><br>Identify and sign-post individuals that would benefit from reducing their alcohol consumption.<br><br>Increase dental attendance for individuals most at-risk of oral cancer, in order to identify and treat as early as possible.<br><br>Utilise community health champions to raise awareness of the signs and symptoms of oral cancer. |
| **Continue to recommission lost dental activity and mitigate the effects of contract hand backs (Issue 6 and 7)** | Full and open procurements in North Cumbria<br><br>Continue with short term initiatives to re-commission lost activity from existing practices.<br><br>Continue with commissioning additional sessions and top up credits to support urgent care access and access for vulnerable high needs groups.<br><br>Workforce initiatives to improve recruitment and retention initiatives in targeted areas with existing workforce challenges.<br><br>Explore innovative procurement innovations to make NHS contracts more attractive to the market. Ensure contracts are not entirely based on achievement of UDA activity but based on a mixed service model including payments that promote: prevention activity, and the provision of urgent care, and access to new patients. |
| **Use local commissioning powers to support existing dental practice to maintain NHS dental services and support recruitment and retention of the NHS workforce (Issue 8)** | Consider proactive enhanced payments to identified “high risk” practices to ensure continuing financial viability on NHS contracts. Enhanced payments could target increases in new patient access, urgent care, treatment for high needs patients and vulnerable groups and a focus on prevention.<br><br>Develop a menu of flexible commissioning options across NENC to incentivise and support practices to |

| | |
|---|---|
| | deliver: urgent care, access for high needs patients and prevention initiatives.<br><br>Build on existing workforce recruitment and retention initiatives in targeted areas of North Cumbria, North Northumberland, Durham and Darlington. |

## 9. What additional needs assessment is required?

*The following are issues/gaps that need addressing to provide a more complete needs assessment:*

- Update needs assessments of specialist areas: minor oral surgery, sedation services, domiciliary care, pathways to inform transformational commissioning opportunities.
- Needs assessments to inform pathway reviews of paediatric dentistry and special care dentistry to inform transformational commissioning opportunities.
- A needs assessment of out-of-hours and urgent care services.
- An epidemiology census study of 5-year-old children is required in 2023/24 to fully assess the impact of COVID. The current small survey sample size may be masking the true effect of increased dental decay due to COVID.
- A more robust recording and oversight of dental GA activity in NENC CDS services.
- Use the data compendium of locality level data (by local authority middle super output areas- MSOAs) to inform commissioning of services.

## 10. Acknowledgements and key contacts

### Acknowledgements

Rapid Oral Health Needs Assessment North East and North Cumbria (October 2022) produced by Mr Stuart Worthington Specialist Trainee in Dental Public Health

### Key contacts

The North East Dental Public Health Team. NHS England