Oxfordshire NHS
Primary Care Trusts

Oral Health Strategy

for

Oxfordshire PCTs

provisional
to be updated 2007

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1 INTRODUCTION

1.1 Purpose of Strategy

This Oral Health Strategy aims to:

1. Promote a high standard of oral health through partnership working between all the groups and agencies working to improve health
2. Identify priorities for the planning of primary and secondary dental care services for e.g. patients with special needs or areas of deprivation
3. Promote the recruitment and development of a skilled workforce which is able to effectively meet the needs of the population

1.2 **Consultation process**

The document was consulted through Public Health teams, Local Dental Committee, patient forums and primary care teams.

2 POPULATION DEMOGRAPHICS

2.1 Source of data

The information about population demographics in Oxfordshire has been summarised by the Oxfordshire Public Health Information team. The main data inputs were:

- Historical trends in population growth at county and district level (from the Office for National Statistics) which give migration and mortality assumptions. This includes the latest mid-year estimates for 2001, 2002 and 2003 which were provided by ONS in September 2004.
- Actual births by ward (2001/02) and Government Actuary Dept 2002-based fertility projections.
- Census 2001 resident and communal establishment populations by ward.
- Actual and planned housing completions by ward provided by City and District planners.

2.2 Primary Care Trusts (PCTs) in Oxfordshire

The geographic boundaries for PCTs, as set out in the original establishment orders, are based on wards as at 1999. The wards were allocated to PCTs by analysing GP population data and placing a ward in a PCT where more than 50% of the population were registered with a GP practice in that PCT.

Ward boundaries in Oxfordshire changed in 2002 and 2003 so, to enable PCTs to analyse ward datasets in the future, the "50% rule" was applied again, using a GP population download from Exeter provided by Thames Valley Primary Care Agency. For analysis purposes the Public Health Information Team have allocated whole wards to each PCT in Oxfordshire. These do not “fit” the geographical boundaries as set out in establishment orders but have been agreed by Directors of Public Health.

2.3 Population growth

According to the Census surveys of 1991 and 2001, Oxfordshire county is recorded as having a 10% growth from 1991 to 2001. The population for Oxfordshire’s PCTs as a whole is projected to increase by over 34,000 people, or 5.6% from 2001 to 2011. Apart from South East Oxfordshire PCT, the population of PCTs in Oxfordshire are expected to grow with South West Oxfordshire PCT experiencing the largest increase (10.8%).

Table 1 – Projected population change 2001 to 2011

PCT	2001 2011 2001	Difference to 2011		Percentage change 2001 to 2011
Cherwell Vale	122,293	131,046	8,753	7.2%
North East Oxfordshire	71,736 77,352		5,616 7.8%	
Oxford City	156,198	158,658	2,460	1.6%
South East Oxfordshire	74,668	71,375	-3,293 -	4.4%
South West Oxfordshire	193,922	214,787	20,865	10.8%
All Oxfordshire's PCTs	**618,817**	**653,217**	**34,400**	**5.6%**

Source: GLA ward population projections for Oxfordshire, Daventry and South Northamptonshire

The increase in population is primarily in the older age groups, particularly those aged 85 years and over. This reflects the ageing population nationally. The number of children under 10 is expected to decline (see Table 2). This may be in part due to a reduction in females of child-bearing age.

Table 2 – Population change for Oxfordshire's PCTs by broad age bands 2001 to 2011

	2001	2011	Difference	Percent change
0-4 years	36,544	34,195	-2,349	-6.4
5-9 years	38,365	34,947	-3,418	-8.9
10-19 years	77,877	80,889	3,012	3.9
20-44 years	232,536	231,855	-681	-0.3
45-64 years	143,748	169,207	25,459	17.7
65+ years	89,748	102,124	12,376	13.8
Total	618,817 653,217 34,400 5.6			
85+ years	11,538	14,091	2,553	22.1

Source: GLA ward population projections for Oxfordshire, Daventry and South Northamptonshire

2.4 High growth wards

Wards which are predicted to undergo the greatest percentage increases in population from 2001 to 2011 by PCT are shown in Table 3.

Table 3 – High growth wards

PCT	Ward	% growth in population 2001 to 2011
Cherwell Vale	Banbury Hardwick	+40%
North East Oxfordshire	Ambrosden & Chesterton	+66%
	Bicester Town	+39%
Oxford City	Barton and Sandhills	+21%
	Iffley Fields	+14%
	Cowley Marsh	+14%
South West Oxfordshire	Carterton North East	+119%
	Didcot All Saints	+114%
	Witney North	+47%
	Didcot Ladygrove	+44%
	Witney West	+34%
	Abingdon Abbey and Barton	+26%
	Grove ward	+25%
	Faringdon & the Coxwells	+12%

Source: GLA ward population projections for Oxfordshire, Daventry and South Northamptonshire

2.5 Household forecasts

Oxfordshire PCTs are predicted to have an overall increase in households of 11.2%. South West Oxfordshire PCT shows the largest increase (15.2%) and South East Oxfordshire the smallest (3.5%). See Table 4.

Table 4 – Household forecasts for Oxfordshire's PCTs

	Households			
PCT	**2001**	**2006**	**2011**	**% change 2001 - 2011**
Cherwell Vale	50,043	52,797	55,799	11.5
North East Oxfordshire	28,531	30,179	32,175	12.8
Oxford City	59,971	63,564	65,279	8.9
South East Oxfordshire	30,481	31,128	31,540	3.5
South West Oxfordshire	77,139	81,764	88,901	15.2
All PCTs in Oxfordshire	**246,165**	**259,433**	**273,695**	**11.2**

Source: GLA ward population projections for Oxfordshire, Daventry and South Northamptonshire

3 ORAL HEALTH STATUS

3.1 CHILDREN'S ORAL HEALTH

The main diseases that affect children are:

1. Dental caries (tooth decay)
2. Dental erosion
3. Dental injuries
4. Malocclusion

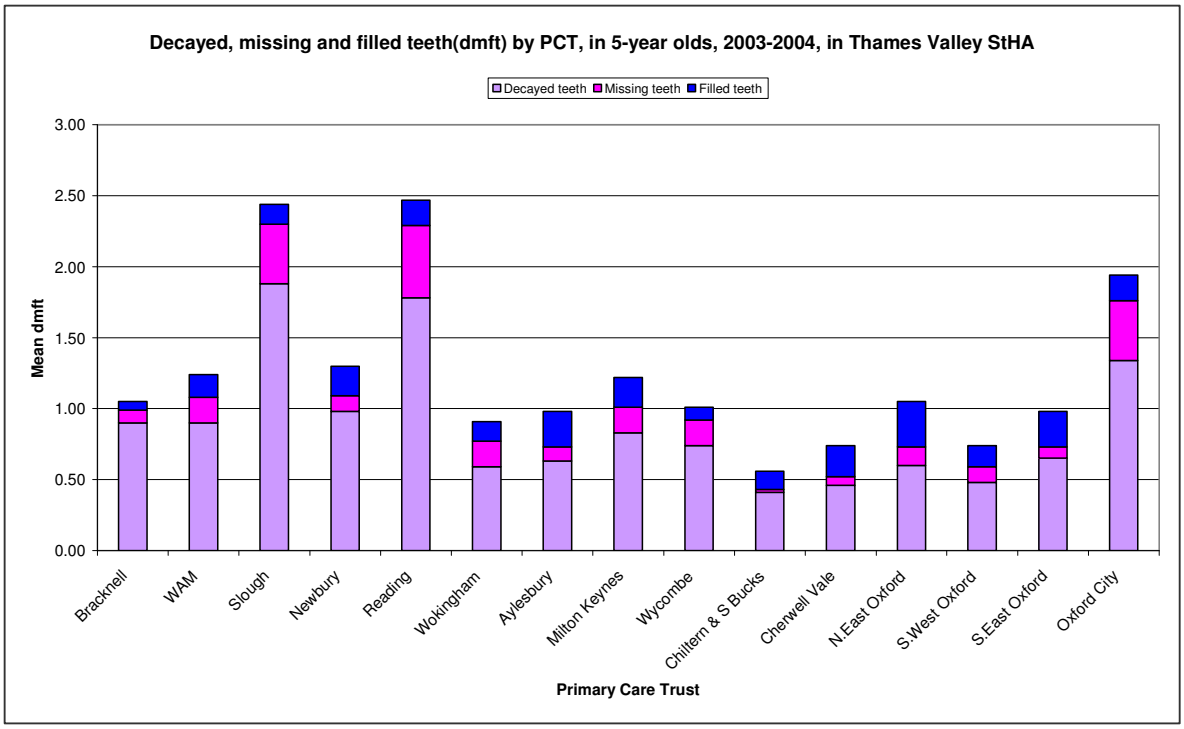
3.1.1 Dental Caries

Dental caries occurs when bacteria within plaque on tooth surfaces convert sugars in the diet to acids which cause demineralisation of the enamel layer of the tooth. If this process continues unchecked, a cavity will eventually appear in the tooth. Frequent consumption of sugary foods and drinks increases the risk of tooth decay, particularly if oral hygiene habits are poor[1].

Dental decay is measured using the decayed, missing, filled teeth index; dmft for primary teeth and DMFT for permanent teeth. A DMFT or dmft more than 0 indicates experience of decay. Data on children's oral health is collected annually as part of a nationally co-ordinated epidemiological programme, in line with a protocol set out by the British Association for the Study of Community Dentistry (BASCD). The variation in the mean number of decayed (d), missing (m) and filled (f) teeth in PCTs across TVHA region is illustrated below (Graph 3.1). Detailed figures for each PCT can be seen in table 2. The dmft values reflect the link between caries and deprivation. This is shown particularly by Oxford City, which has a mean dmft twice that of the other PCTs in Oxfordshire. In the national 2003 Children's Dental Health Survey the dmft was 1.6. The Department of Health target for 2003 for 5-year-old children was ≤1.

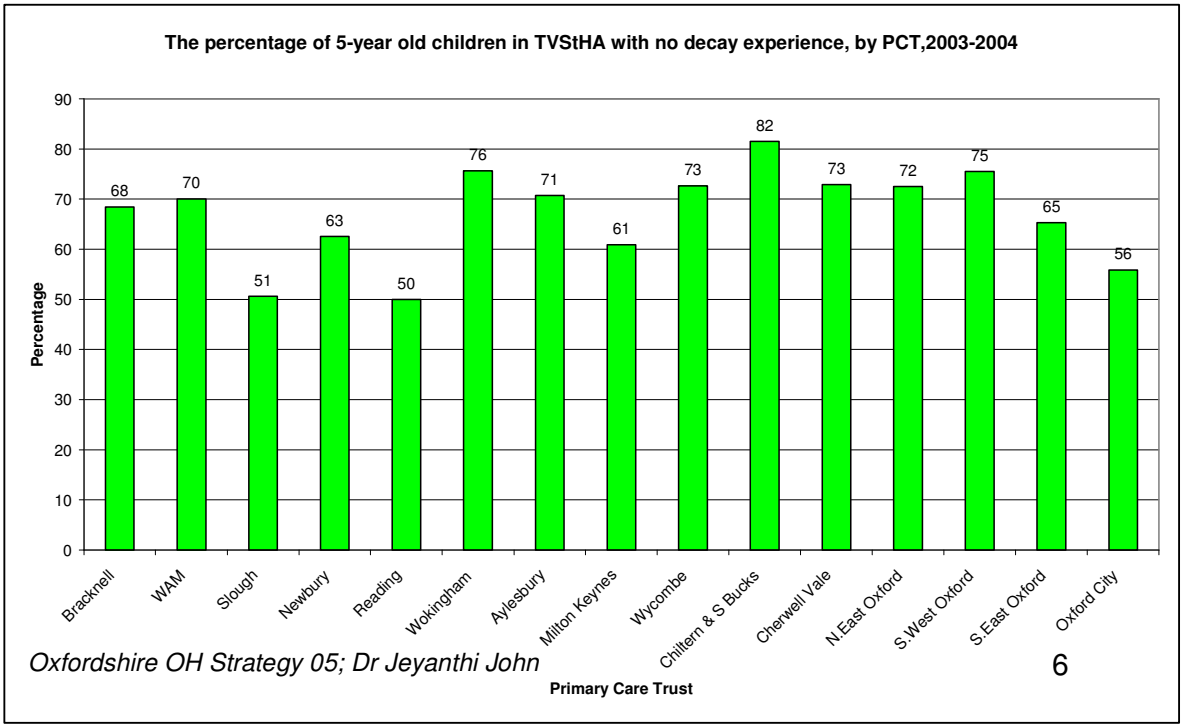
[1] Levine,RS and Stillman-Lowe, CR. The Scientific Basis of Oral Health Education. British Dental Association 2004.

Graph 3.1



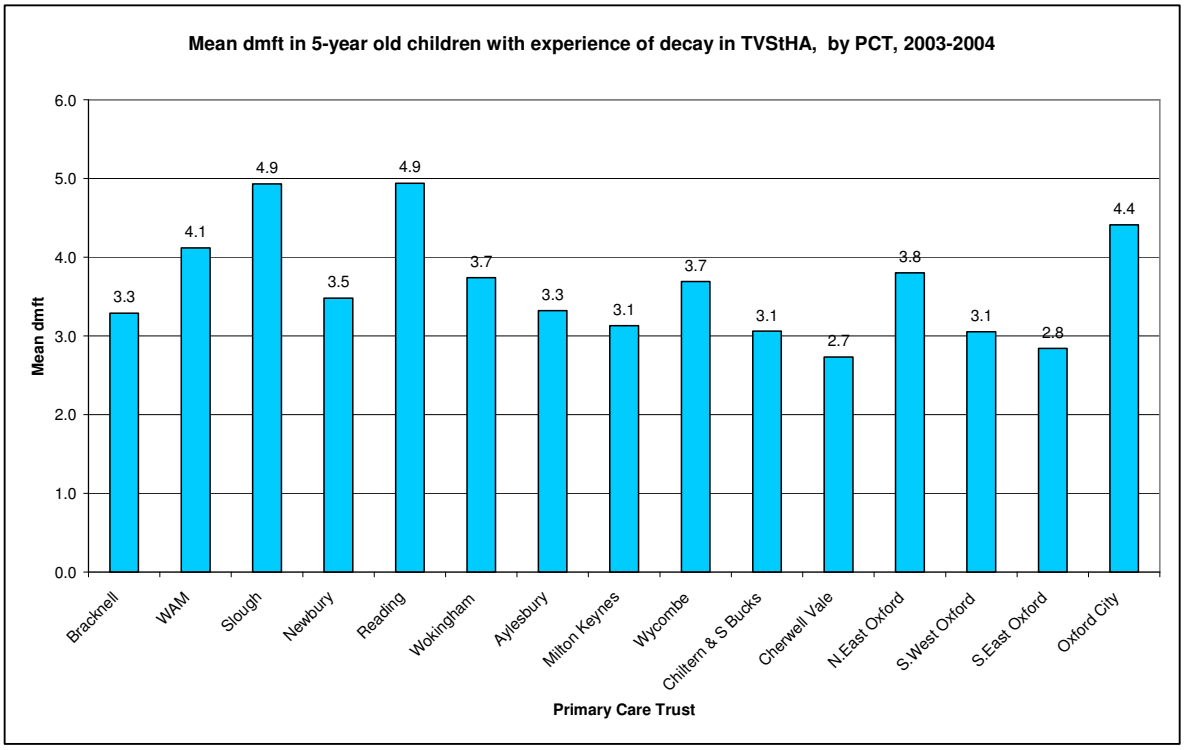
The percentage of children with no decay experience can be seen in Graph 3.2. In the national 2003 Children's Dental Health Survey the proportion of children with no decay experience was 57%. The government target for 2003 was achieving a total of 70% of 5-year-old children who were caries free. In Oxfordshire Cherwell Vale, North East Oxfordshire and South West Oxfordshire PCTs have exceeded that target. South East Oxfordshire PCT marginally outside that range. Oxford City PCT has a low percentage compared to most Thames Valley PCTs.

Graph 3.2



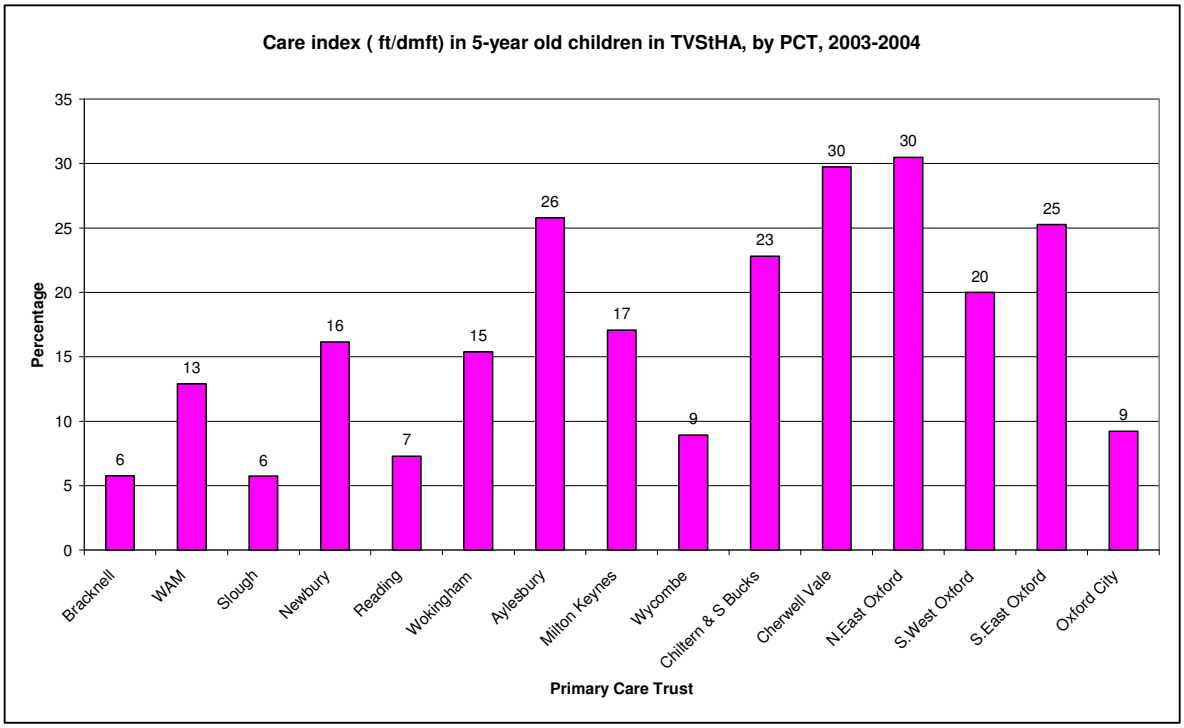
As can be seen by graph 3.3, the level of decay is not evenly distributed amongst the children and in some areas only 20% of the children have experienced/have active decay and contribute to the dmft levels in the PCT. Graph 3 shows the level of decay only in those children with decay or those who have experienced decay, i.e. with a dmft with 1 or more. This gives a more accurate picture of the level of decay in those children with decayed missing or filed teeth. For most of the PCTs the mean dmft in those children with decay experience was above 3. In the national 2003 Children's Dental Health Survey, the dmft in children with obvious experience of decay was 3.7

Graph 3.3



Graph 3.4 shows the care index across the PCTs in the Thames Valley. The care index (ft/dmft) reflects the restorative care of those who have suffered disease, it therefore has to be viewed in conjunction with dmft. These results are of interest in studying the provision of dental services to this age group with a lower care index indicating that less care. Oxford City has the lowest care index in Oxfordshire and is in the lowest 5 of all PCTs in the Thames Valley. The South Oxfordshire PCTs have care-indices that are in the top 5 in the Thames Valley indicating that the children here have received more dental care. There may be many reasons for differences in care that people receive including a reluctance to attend for dental care and poor access.

Graph 3.4



There is no local data for 15-year-olds. Information about this group is available from the national 2003 survey. A total of 50% of this group had sound teeth showing improvement from 37% in 1993 and 7% in 1983. The dmft also showed large improvements from 5.9 in 1983 to 2.5 in 1993 to 1.6 in 2003.

Dental decay is not equally distributed amongst the population, as with many diseases it is strongly associated with socio-economic deprivation. The inequalities that exist throughout England and across ethnic groups show that there is no single cause of poor oral health but a range of factors including unemployment, poverty, social deprivation and lifestyle. In children approximately 80% of the disease is found in 20% of the children, the children most affected coming from the lower socio-economic groups. Where prevention has failed the only treatments available are fillings and extractions, neither of which is desirable particularly in a young child.

3.1.2 Dental Erosion

Dental erosion, wearing away of the surface of the teeth appears to be an increasing problem amongst young people. The cause is usually frequent consumption of soft drinks and juices, including sports drinks and diluted squashes. The principal ingredient in most of these drinks is citric acid. There is no universally accepted index for measuring the extent of erosion but most clinicians accept that it has increased over the last 20 years[2] (Levine and S-Lowe 41).

[2] Levine,RS and Stillman-Lowe,CR. The Scientific Basis of Oral Health Education.British Dental Association 2004.

In the 1993 Children's Dental Health Survey about a quarter of children aged 5-6 years were found to have dental erosion into dentine and pulp.

Table 2.2 Percentage of UK 5 and 6-year-old children with erosion into dentine and pulp on the lingual surfaces of the primary incisors

Age	England	Scotland	Wales	Northern Ireland	UK
5	23	34	22	12	24
6	22	35	18	15	23

3.1.3 Malocclusion (misaligned or malformed teeth)

Malocclusion can have a major impact on psychological well-being and social embarrassment. Orthodontic treatment to correct this is available on the NHS where there are real restrictions that this imposes on the quality of life. Orthodontic need is measured on a scale, the Index of Orthodontic Need (IOTN). IOTN consists of two components, the dental health component (DHC) and the aesthetic component (AC). The dental health component is a grading of 1–5, where 1 indicates no need for treatment and 5 indicates great need for treatment. The grade allocated depends on the measurement of the most severe occlusal trait. The aesthetic component of the index is designed to complement the dental health component by recording the severity of anterior aesthetic tooth arrangement. A Grade 1 score would require no aesthetic need and a score of grade 10 would indicate great aesthetic need for treatment

3.1.4 Dental injuries

Dental injuries can occur during falls or other accidents or may be sports-related. Mouthguards help prevent dental injuries in contact sports. The prognosis for a tooth that has been injured is greatly affected by the immediate management of the injury.

3.2 ADULT ORAL HEALTH

3.2.1 Dental Caries

There is no local information about adult oral health. The latest information we have is from the 1998 UK Adult Dental Health Survey[3]. Adult oral health has improved significantly over the last several years.

More and more adults are keeping our own teeth. After age, educational qualifications had the next largest effect on the odds of being without any teeth. Those with no qualifications were almost nine times more likely and those with qualifications below degree level four times more likely to be edentate than those with degree level qualifications. Edentulousness is expected to drop to 8% in 2008 and to 5% in 2018. The condition of teeth has also improved. Almost a third of those aged between 16 and 24 had no fillings.

3.2.2 Periodontal Disease

Periodontal disease (gum disease) is an infection of the tissues supporting the teeth. In early stages it presents as redness along the margins of the teeth (gingivitis) and is reversible with institution of good oral hygiene procedures. In later stages it can result in bleeding, gums detaching from the teeth, loss of bone. Eventually teeth can be lost.

The presence of periodontal pocketing and loss of gum attachment (receding gums) are proxy measures for severity of gum disease. The prevalence of pocketing and loss of attachment increased with age with 14% of those aged between 16 and 24 years experiencing some loss of attachment compared with 85% of those aged 65 and over.

3.2.3 Oral Cancer

Each year in the UK, about 3800 new cases are diagnosed and there are around 1700 deaths. In England and Wales, oral cancer is the eleventh most common malignancy in men and the sixteenth most common in women[4]. The incidence of oral cancer increases with age and in the UK the majority of cases (85%) occur in people aged 50 or over. Early detection greatly improves survival rates. The 5-year survival rate for early stage tumours is 80%, but falls to 15% for advanced ones[5].

Tobacco-use and excessive alcohol consumption are the 2 main risk factors. Those who use tobacco have a 2-18 times increased risk of developing oral cancer compared to non-smokers[6] (). All forms of tobacco are harmful including cigarettes, cigars and pipes. The use of chewing tobacco in combination with betel quid and other substances puts people at increased risk. Many studies have confirmed that alcohol increases the risk of oral cancer independently of tobacco exposure. About

[3] Nuttall,N. A Guide to the UK Dental Health Survey 1988. British Dental Association 2001.
[4] Quinn, M et al. Cancer trends in England and Wales 1950-1999. The Stationery Office, 2001
[5] Williams, S. Oral cancer: Prevent it before it is too late! University of Leeds; 1999.
[6] Background papers for National Strategic Conference for the Prevention and Control of Oral and Pharyngeal Cancer. Centres for Disease Control and Prevention. 2001.

75-18% of all oral cancer patients frequently consume alcohol[7]. Those who smoke excessive amounts of alcohol (more than 21 units for women and 28 units for men) and who smoke more than a pack of cigarettes per day are up to 24 times more likely to develop oral cancer than non-users of alcohol and tobacco[8]. It is known that people from lower social classes are at increased risk from oral cancer. This may be related to the higher rates of smoking and alcohol use coupled with lower use of health services in these populations.

3.3 SPECIAL POPULATIONS

3.3.1 Special Needs

Special needs patient would include people with:

Learning difficulties
Mental illness
Physical disabilities
High-risk infections
Medical conditions which put them at risk during dental treatment or increase their risk of dental disease.

Many of these people will be able to maintain good oral health and obtain dental treatment without extra support. Others may require help with accessing appropriate dental care. These patients and/or their carers may also require special advice about maintaining good levels of oral health.

Patients with special needs are generally seen in the Oxfordshire Priority Dental Service. The Service employs salaried dental personnel who are specially-trained and have access to specialised equipment to enable these patients to be treated. It may be possible for them to obtain treatment in a general practice which has the required expertise and/ or access to specialised equipment to treat them.

3.3.2 Prisons

In April 2003, the Department of Health published a strategy document aimed at developing and modernising the provision of dental services in prisons[9]. The document was published in response to evidence that the current provision of dental care does not adequately meet the needs of prisoners. Funding responsibility for prison health services in England was transferred from the Home Office to the Department of Health in April 2003.

The document aims to help prisons, working with their NHS partners, to:

1. Improve the quality of dental care in prisons by ensuring high quality standards are in place based on the principles of clinical governance and robust audit trails.

[7] American Cancer Society. What are the risk factors for oral and oropharyngeal cancer? 2001.
[8] Background papers for National Strategic Conference for the Prevention and Control of Oral and Pharyngeal Cancer. CDC 2001
[9] Department of Health and HM Prison Service. Strategy for Modernising Dental Services for Prisoners in England 2003

2. Work to raise the awareness of good oral health throughout the prison, amongst prisoners, prison staff and voluntary agencies working in prisons.

3. Identify resources and operational issues specific to prisons that are required for each prison to meet the dental needs of prisoners.

4. Ensure that cost-effective dental services are commissioned to meet the oral health needs of prisoners including appropriate performance measures.

5. Develop a model service specification for the provision of dental services in prisons that will enable prisoners to have access to dental care appropriate to their needs.

Funding responsibility for prison health services in England was transferred from the Home Office to the Department of Health in April 2003. Eventually, all aspects of prison health will be transferred to the NHS. Primary Care Trusts will take responsibility for the commissioning of health services to prisons in their areas from April 2006. Prisons will continue to play a key role in the developing and modernising of dental services, through prison leads who will work with PCTs throughout this process.

4 ORAL HEALTH CHALLENGES AND PRIORITIES

4.1 PREVENTIVE DENTISTRY

4.1.1 Shifting the primary care focus from therapeutic to preventive

Dentistry to date has a predominantly disease-orientated focus. This was appropriate in the past as the prevalence of dental disease in the population was high. There was a need for services to be oriented towards meeting the high need for treatment. In the past few decades, there have been major improvements in oral health but services have not caught up with the change. There is also much more knowledge about the aetiology of dental disease which facilitates a more preventative approach. The Scientific Basis of Oral Health Education lists the actions that would promote good oral health: a healthy diet, good oral hygiene, use of fluoride and regular oral examinations. These simple measures would reduce the human cost (pain and suffering) and economic cost (workdays lost) of dental disease. Parents should also receive advice on maintaining good oral health for their children. This is line with the Children's National Service Framework[10] which recommends focusing on "early intervention, based on timely and comprehensive assessment of a child and their family's needs". The change in focus for oral care services will impact on the workforce as this required a change in skill-mix, resource development and training needs.

Targets:

- Encourage greater focus on preventive dentistry in primary care by providing training and resources to all members of the dental team. This will involve liaising with the Oxford Deanery to provide appropriate courses.

- Ensure all patients get advice about maintaining good oral health through cleaning their teeth regularly and effectively with fluoridated toothpaste. Ensure that parents are advised about looking after their children's oral health needs.

- To achieve a Oxfordshire-wide dmft for 5-year-olds xx by xxx (await England OH Strategy)

4.1.2 Water fluoridation

A systematic review published in the BMJ found that water fluoridation was associated with an increased proportion of children without caries and a reduction in the number of teeth affected by caries[11]. The reduction in tooth decay was found to be greatest in the areas where the levels were highest. There was an increased prevalence of dental fluorosis but there was no evidence of any other potential

[10] Department of Health. National Service Framework for Children, Young People and Maternity Services 2004
[11] McDonagh,MS et al. Systematic review of water fluoridation. BMJ v321:855-859. 7Oct 2000

negative effects. There is also some evidence that water fluoridation reduces the inequalities in dental health across the social classes in 5 and 12 year old children[12].

Since 2003, water fluoridation can be implemented in areas where there is strong community support. There is a strong case for targeted water fluoridation in areas where oral health is known to be poor, particularly in areas of deprivation. The Children's NSF describes dental decay as "an almost entirely preventable disease". It states that "the fluoridation of public water supplies should be promoted as a public health measure to reduce dental caries and inequalities in dental health".

Targets:

- Discuss feasibility of public consultation for targeted fluoridation in areas of greatest need.

- Disseminate information on the effectiveness and safety of water fluoridation to all health care workers and the public.

4.2 PROMOTING ORAL AND GENERAL HEALTH

The Public Health White Paper, Choosing Health (DH 2004) states that:

"Many of the issues that affect people's general health are important for oral health too. Under the new contractual arrangements for NHS dentistry, from October 2005 dentists will give a new focus to advice on the prevention of disease, lifestyle advice and the discussion of options for care. They could, for example, work in conjunction with the wider primary care public health team to provide advice on smoking, and diet and nutrition – including prescribing sugar free medicines where appropriate."

Many lifestyle factors that affect general health also affect oral health. For e.g. tobacco-smoking combined with excessive alcohol consumption greatly increases the risk of oral cancer, as well as lung cancer and heart disease. This focus on risk factors instead of disease is known as the "common risk factor" approach[13]. Oral health promotion programmes are sometimes organised in isolation from other health programmes. This may result in duplication of efforts or conflicting messages. Encouraging all health professionals to disseminate the same health lifestyle message would promote good oral and general health.

Research carried out in Dundee has shown that dental teams do provide dietary advice but the advice varies widely in content and the extent to which it is carried out in dental practice[14]. This research found that dietary advice often followed a clinical trigger e.g. new caries, and often took the form of a single statement from the dentist. Dentists' knowledge about general nutrition about current recommendations for certain food groups were inconsistent. Dental teams will need training and resources to enable them to provide or extend their dietary advice so that is consistent with that given by other healthcare groups. For e.g. recommending that patients reduce the

[12] British Fluoridation Society, UK Public Health Association, British Dental Association, Faculty of Public Health. One in a million- The facts about water fluoridation. 2004.
[13] Sheiham,A and Watt,RG. The common risk factor approach: a rational basis for promoting oral health. Community Dent Oral Epidemiol. 2000 Dec;28(6):399-406.
[14] Promoting dietary change in low-income communities: assessing the feasibility of dietary interventions in General Dental Practice; Anderson et al; Working Paper Series: Number 15, Centre for Applied Nutrition Research, University of Dundee; June 2000

number of sugary snacks is helpful in that it reduces the risk or dental decay as well as obesity but it would be even more helpful to extend that advice and suggest what foods would be healthy to maintain good oral as well as good general health.

Research in the Thames Valley (counties of Berkshire, Buckinghamshire, Northamptonshire and Oxfordshire) has shown that an increasing number of dentists now provide smoking cessation advice to their patients[15]. However, only 48% reported that they routinely recorded their patients' smoking status and even fewer (27%) advice those who smoke to stop using tobacco. Advising patients who use tobacco to stop doing so has many implications for health including reducing the risk of oral cancer, heart disease and lung cancer.

Part of the reason for the patchy health promotion that occurs in general dental practice is the busy schedule that dental teams have to adhere to if they are to provide all the dental care that their patients need. Training and resources may encourage and facilitate more health promotion in general dental practice. The new dental agenda stresses the importance of prevention. Dental teams will be able to provide preventive as well as therapeutic care for all their patients and help PCTs move closer to their health targets.

Oral health improvements should be led by, but not confined to oral health professionals. Just as it would be advantageous for oral health professionals to give out messages that would improve general health, it is also beneficial for all health professionals to be able to promote good oral health. Health visitors, for e.g., may be vital in reaching deprived populations who may not access dental services. The Health Development Agency describes health promotion as comprising of a range of complementary approaches. These include building healthy public policy, creating supportive environments, strengthening community action, reorienting health services and developing personal skills. The success of these approaches largely depends upon multi-sectoral working.

Targets:

- Disseminate information on diet to all health professionals including dental teams so that everyone gives consistent clear advice. Dietary advice should be sensitive to the needs of ethnic minority groups.

- Encourage dental teams to provide smoking cessation advice to patients who smoke. Work with Smoking Advice Service to organise training for teams.

- Disseminate information about oral health to all health professionals including health visitors so that everyone gives out consistent oral health messages.

- The Children's NSF requires services to "introduce a new Child Health Promotion Programme designed to promote health and well-being of children pre-birth to adulthood". Oral health promotion should be included in this Programme.

[15] John,JH et al. Smoking cessation interventions in the Oxford region:Changes in dentists' attitudes and reported practices 1996 – 2001. BDJ 195(5):270-275. 2003.

4.3 ACCESS TO DENTAL CARE

4.3.1 Routine care

Routine therapeutic and follow-up dental care will continue to be necessary to everyone. In recent years, there has been a decline in the number of practices offering NHS care. The advent of local contracting procedures has enabled PCTs to negotiate local contracts with practitioners. These contracts will enable practitioners and PCTs to work together to deliver NHS dentistry to the local population. Most practitioners carry out a mix of private and NHS care. This is beneficial to patients as it provides choice and allows patients to access certain treatments that are not available on the NHS. However, there should be clarity about charges, including advice on exemption from charges.

Although oral health has improved in the county, there are still parts of the population where high disease levels persist. This has been related to two social factors[16]. The first is social deprivation, with high levels of caries often seen in more deprived areas. Poorer groups often have greater needs but may not seek or be able to utilise services effectively. The second is ethnicity which is possibly related to variations in oral hygiene practices within different cultures. Studies have identified a much higher prevalence of dental decay in five-year-old children from Asian backgrounds compared to their white counterparts[17,18]. There are also disparities in the oral health status of the population in different PCTs (see Oral Health Status section). Mapping and demographic data will identify areas where oral health needs are high to enable planning of services in these areas.

4.3.2 Specialist care

Oxfordshire currently has a shortage of specialist practitioners providing NHS care. This means that local residents need to travel to Birmingham or London to obtain specialist care in areas such as periodontics. We are awaiting guidelines for the development of "dentists with special interests" (DwSIs). These will be dental practitioners who are not on recognised specialist lists but have specialist training in a particular area. PCTs may be able to contract with them to provide certain types of specialist care. The guidelines will provide information about how to monitor the care provided by these practitioners to ensure that they are of a high quality. Discussions are underway across the three counties to establish a network of specialist practitioners and DwSIs across the region.

4.3.3 Emergency/ out-of-hours care

To date, GDPs were responsible for 24-hour care for patients registered with them. Dental Access Centres provide care for non-registered patients but these are often extremely busy. PCTs will eventually be responsible for organising out-of-hours or emergency care for their populations. A definition of emergency care is necessary, together with a system for establishing a system of priorities. Protocols would help to triage calls either through NHS Direct or another appropriate organisation within the

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[16] Levine,RS and Stillman-Lowe, CR. The Scientific Basis of Oral Health Education. British Dental Association 2004.
[17] Pine et al, Inequalities in North-west, Community Dental health 2003
[18] Gray et al, Community Dental Health 2000

county. Ideally, out-of-hours dental care should be incorporated with out-of-hours medical care. Specific sites which include both medical and dental care facilities with on-site security would ensure the safety of staff and patients. Such a model has been established successfully in Newcastle[19].

4.3.4 Special needs groups and secure institutions

With the new contracting procedure, services for special needs currently provided by the Personal and Community Dental Service (PCDS) may be provided by the general dental practitioners who have the necessary skills. The service will need to be coordinated by the PCTs and PCDS and the quality of care monitored to ensure that the same standard of service is delivered via both the services.

Targets:

- Work with public health information team to identify target areas for improved dental access
- Work with other organisations and groups to access populations that currently have poor oral health and/or poor access to dental care, for e.g. elderly and deprived populations
- Establish a network of specialist practitioners across the Thames Valley region in collaboration with Buckinghamshire and Buckinghamshire, which will include specialists and dentists with special interests.
- Establish an effective system of prioritising and dealing with dental emergencies.
- Special services for special needs groups to be delivered through PDS and GDS practitioners and coordinated by the PDS.
- Establish an effective system of delivering care to those in secure facilities with a system of triaging for emergency sessions outside clinical sessions.

4.4 WORKFORCE

4.4.1 Recruitment

The Government has made a commitment to increasing the number of dentists in the country through a combination of increased intake into dental schools, helping those who have left dentistry (e.g. to raise a family) to return to the profession, or through international recruitment. In Oxfordshire, we are working with Berkshire, Buckinghamshire and the Thames Valley Strategic Health Authority to encourage more dental graduates to move to the area. A robust recruitment plan is in place locally which includes training joint training opportunities between the GDS, Salaried Services and hospitals.

[19] Evans et al. Out-of-hours emergency dental services – development of one possible local solution. 191(10):550-554

There are severe recruitment problems for professionals complementary to dentistry (PCDs) i.e. dental nurses, dental therapists and dental hygienists. From a skill-mix perspective, it is important to have different categories of dental professionals working together to provide care for patients. This enables the most appropriate person to carry out the treatment for the patient, making the practice more efficient. Currently, there is no national drive to improve recruitment in these categories. Locally, we are trying to improve recruitment through advertising and providing more training opportunities.

4.4.2 Training

Developing training programmes within the Thames Valley region for PCDs will facilitate the development of better skill-mix within the county. Collaborative work is underway to develop dental nurse training within the Thames Valley region.

Continuing education is also important for all categories of dental staff. Dentists are currently required to participate in 250 hours of continuing education over 5 years, of which 75 hours should be verifiable e.g. through attending a course. There is no requirement for other categories of staff. All dental team members are encouraged to have personal development plans that identify areas where further training may be beneficial. It may also be useful for PCTs to work with the local Deanery to organise education programmes for the team which tie in with PCTs objectives, for e.g. in smoking cessation.

With the development of "dentists with special interests", there is the possibility of organising training locally to help practitioners develop skills in their area of interest. This would help address the skills shortage in certain specialties within the county.

Targets:

- Work with neighbouring counties and SHA on developing positive recruitment strategies for categories of dental staff
- Joint training posts between GDS, Salaried services and hospital dental services
- Vocational training posts within salaried services
- Encourage all dental team members to develop a PDP to identify training needs
- PCTs to work with local Deanery to develop training programmes in areas that link in with PCT priorities e.g. in smoking cessation.
- Practitioners and PCTs to work together to develop training for "dentists with special interests".

4.4.3 Clinical Governance

Clinical governance was introduced to the National Health Service (NHS) in 1998. The aim was to make NHS health professionals and organisations accountable for continuing to improve care within the service. Clinical governance does not entail any new concepts, rather it involves integrating previously disparate mechanisms which all relate to improving quality of care in practice. This includes health and safety protocols, handling patient complaints, dealing with medical emergencies in the practice and clinical audit.

All dental practices are required to have a clinical governance system in place and provide annual reports to their local PCTs. In Oxfordshire this is done using a simple questionnaire survey that is sent to all practices. The survey enables PCTs to identify areas where the practices report requiring more training and resources. PCTs can then work with the local deanery and other groups to develop appropriate training. In Oxfordshire, dentistry is already incorporated into Oxford City PCT clinical governance plans and discussions are underway to do the same with the North and South PCTs.

Part of the remit of clinical governance is for dental teams to practice evidence-based dentistry i.e. base their treatment plans on current evidence including guidelines and protocols produced by the National Institute of Clinical Excellence or reviews produced by Cochrane, in combination with their experience of the patient and, where necessary, the advice of any other health professional who is involved with treating the patient. The PCTs should try to support and monitor this process for e.g. monitoring referrals to secondary care for the management of third molars and circulating new guidelines to practices.

All practices with an NHS contract are required to participate in a clinical audit project. This is funded from central funds and supported through a regional panel. Participation from Oxfordshire practitioners has been very good with positive feedback about the impact on the quality of care. PCTs should continue to support and promote this process.

A Thames Valley Practitioner Advice and Support Scheme (PASS) has been set up for Berkshire, Buckinghamshire and Oxfordshire with representatives from the Local Dental Committees, Dental Practice Advisers and a Consultant in Dental Public Health. Members of this group are being trained as mentors to support practitioners who are having difficulties.

Targets:

- Monitor and support the continued development of clinical governance in dental practices including promotion of the practice of evidence-based dentistry
- Support and encourage practices in meeting their clinical audit requirements
- Support the work of the PASS group

4.4.4 Research

Currently, there is little information regarding dental service needs and demands for the Oxfordshire population. A priority for the dental team is to identify what these are

so as to advice local commissioning teams. Oxfordshire needs to continue to support the national dental epidemiology programmes that are currently in place such as the BASCD surveys. Some areas of primary care practice may require research such as the smoking education study in general dental practice which identified the need for more training in this area. As with the clinical governance survey, training needs can be identified and appropriate training laid on to help dental teams develop their skills and thereby improve the quality of care.

Targets:

- Carry out research in conjunction with public health teams and other groups to identify the needs and demands of the local population
- Continue to support national epidemiological programmes e.g. BASCD
- Carry out research to identify training needs of local dental teams and opportunities to further improve the quality of care in the county.