NHS Haringey

ORAL HEALTH NEEDS ASSESSMENT

July 2009

CONTENTS

1. EXECUTIVE SUMMARY AND RECOMMENDATIONS

NHS Dentistry was fundamentally reformed in April 2006. The introduction of the new dental contract and the devolution of the dental budget to PCTs has meant that PCTs must engage in world class commissioning of dental services to meet the needs of their local population. An oral health needs assessment is fundamental to this.

Since the 2006 reforms, access to NHS dentistry has fallen across England. Improving access to primary care dentistry is now a key NHS target. While the provision and uptake of dentistry is relatively good in Haringey (particularly for children) there is evidence that the public is not fully aware of the services that exist, how to find out about those services or the cost of services.

The overall oral health picture in Haringey is above both the national and London average. However, standards are not consistent across the borough and there are areas where dental disease levels give cause for serious concern. These areas need to be a priority for oral health promotion programmes. In some areas where deprivation is high, uptake of services appears to be particularly low. Efforts need to be made to improve uptake of services in these areas.

At present some dental work is referred to hospitals which could be dealt with more quickly and cost-effectively in a primary care setting. At the same time dentists are unable to get referrals accepted by hospitals for certain types of treatment.

The quality of GDP premises in Haringey is cause for concern and there is evidence of significant room for improvement in the overall understanding and implementation of cross-infection control issues by dentists.

In the development of this document NHS Haringey has begun engaging with a wide range of stakeholders, some of whom have not been previously engaged in relation to oral health services. What has emerged is an urgent need to review services for some groups of the population such as care home residents, the housebound and drug users.

Implementing the 2006 Dental Reforms has involved a significant workload for NHS Haringey and in the last three years commissioners have had to cultivate the expertise to establish and monitor contracts as well as having to buildand maintaining good working relationships with dentists. The high levels of provision and uptake of dental services in the borough are an indication that the commissioners have responded well to those challenges. However challenges remain for the PCT about how to fully incorporate oral health into the World Class Commissioning agenda.

RECOMMENDATIONS:

ACCESS

The PCT should ensure that all patients are able to access NHS dental services. This should involve the following:

1. **Developing evidence-based clinical pathways between primary care, specialist services and secondary care**
2. **Taking steps to encourage the uptake of services in areas of high need and low uptake, particularly Northumberland Park**
3. **Reviewing the PCTDS and agreeing a Service Level Agreement**
4. **Considering the need for an intermediate special service in endodontics and periodontics**
5. **Reviewing the translation services available to GDPs**
6. **Carrying out a review of the oral health needs of those in residential care homes**
7. **Reviewing the current domiciliary provision and considering the need for the introduction of a transport service**
8. **Developing a communication strategy to publicise the dental access helpline as recommended by the Steele Review**
9. **Assessing the cost of supporting all dental practices to become fully computerised as recommended by the Steele Review**
10. **Continuing to monitoring dental contracts to ensure equality of access to services**

PREVENTATIVE DENTISTRY AND ORAL HEALTH PROMOTION

The PCT should develop an oral health promotion strategy and action plan which should include

1. **Preventative programmes for specific groups, including pre-school children, programmes in schools and programmes for older people**
2. **Steps to develop the skill mix of the workforce in dental practices so as to maximise resources to allow for preventative dentistry and health improvement.**

QUALITY

1. **The PCT should be aware of the need to encourage and reward excellent quality in dental services**

2. **The PCT should continue to monitor and support practices to ensuring that they meet all relevant quality standards**

3. **The PCT should continue to support dental practices to ensure that essential quality requirements are met in infection control and to ensure that all practices are moving towards best practice in decontamination**

THE PCT

1. **The PCT should review responsibility for dentistry on decision-making bodies at all levels of the PCT as recommended in the Steele Review**

2. **The PCT should review Dental Adviser and Dental Public Health capacity to ensure that there is the appropriate support and expertise to allow for World Class Commissioning of Dentistry in Haringey as recommended in the Steele Review**

3. **The PCT should build on the contacts made in preparing this report to ensure appropriate engagement and involvement**

1. CONTEXT

1.1 THE IMPORTANCE OF ORAL HEALTH

Oral health is an integral element of general health and well-being. Good oral health enables individuals to communicate effectively, to eat and enjoy a variety of foods and is important in overall quality of life, self-esteem and social confidence. However oral diseases are very common and their impact on both society and the individual are significant. Pain, discomfort, sleepless nights, limitation in eating leading to poor nutrition and time off school or work are all common impacts of oral disease. Dental treatment is expensive for the individual, for the NHS and society. Although much of the emphasis on oral health is on oral hygiene and the prevention of dental caries, serious diseases such as oral cancer are also part of the oral health context.

1.2 THE IMPACT OF ORAL HEALTH ON THE QUALITY OF LIFE

Clinical indicators of dental problems may not directly reflect the problems people experience as a result of their dentition. Several measuring tools have been developed to provide insights into quality of life experiences of both patients and the public alike. One of the most commonly used instruments is the Oral Health Impact Profile, (OHIP) which looks at the hierarchy of impacts can arise from oral disease. Oral disease can lead to the loss of teeth (impairment). This can lead to difficulties in chewing (functional limitation) or sometimes soreness brought on by dentures (discomfort). This can eventually lead to restricted ability to eat or the need to avoid favourite foods (disability). In extreme cases this may even deter some people from eating anywhere outside the home or with their family members leading to a feeling of social isolation (handicap). OHIP was used in the National Adult Dental Health Survey for the first time in 1998 and showed the following:

- Over half (51%) of adults with teeth reported having experienced one or more oral problems that had an impact on some aspect of their life occasionally or more frequently in the 12 months preceding the survey.

- The most frequently experienced problem among dentate adults during the 12 months preceding the survey was oral pain (40%).

- The next most frequently experienced problems stemming from oral condition were psychological in nature (difficulty relaxing or embarrassment).

- Adults with teeth age 65-74 were the age group least affected. Adults with teeth age 35 to 54 were the most likely to be affected.

- Eight per cent of dentate adults reported being severely affected by their oral health in that they felt their life was less satisfying or that they were totally unable to function at some time in the preceding year as a result of their oral condition.

2. THE NATIONAL POLICY AGENDA

In the last five years dentistry in the UK has undergone a period of major change. In line with the wider modernisation and reform programme across the NHS, a raft of oral health policy and guidance documents have been published.

Key themes of these documents are

- Reforming NHS dentistry
- Improving access
- Improving oral health through tackling inequalities and a greater emphasis on prevention
- Ensuring quality services

2.1 REFORM OF NHS DENTAL SERVICES

The government's plan for the future of dental services was set out in '*Modernising NHS Dentistry - Implementing the NHS Plan*'*(DH September 2000)*[1] which was followed by '*NHS Dentistry Options for Change*' *(DH August 2002* [2]*)*.Dentistry was identified as an integral element of the wider primary care network.

New contractual arrangements for NHS dentistry were introduced in April 2006. Funding for NHS dentistry which had previously been centralised was devolved to PCTs. All dentists providing NHS dentistry became obliged to have a contract with the PCT setting out the amount of work they would do (measured by Units of Dental Activity – "UDA"s) and how much they would be paid for it. Contracts would be based on work done and fees earned during a 12 month reference period from October 2004 to October 2005. Funding for dentistry was to be ring-fenced by PCTs for a 3 year period, which would also be a "guaranteed earnings" period for dentists provided that they continued to carry out the same amount and type of work. However beyond the three year period the intention of the new system was that PCTs would commission dentistry locally based on the oral health needs of their population.

The system of patient charges was also overhauled and simplified. Instead of a different charge for each type of treatment, charges would be according to a 3-tiered system depending on the complexity of the treatment. (The number of UDAs that would be accredited to the dentist for different types of treatment would also be set according to this system.)

Following the introduction of the new system the House of Commons Select Committee published a report on dental services in July 2008.[3] They reviewed the new system according to a number of criteria which included patient experience; clinical quality; NHS commissioning and improving dentists' working lives. They found that the total number of dentists working in the NHS had fallen as had the number of courses of treatment provided. The number of patients seen by an NHS dentist had fallen and access was uneven across the country. They noted that

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002931
[2] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008017

[3] http://www.publications.parliament.uk/pa/cm200708/cmselect/cmhealth/289/28902.htm

dentists claimed that the new system had failed to provide the time and the financial incentive to allow preventative care and that the number of complex treatments had fallen markedly. They also noted that PCT commissioning of dental services was poor and that the new remuneration system based on Units of Dental Activity (UDAs) had proved extremely unpopular with dentists.

In December 2008, the government commissioned an independent review of dentistry led by Professor Jimmy Steele which was published in June 2009, following extensive engagement with patients, dental professionals and the NHS.[4] The report broadly welcomed the introduction of local commissioning but makes a number of recommendations as to how the system can be modified to improve the NHS dental service. It is explicit however that changes should only be introduced after careful piloting. The government has accepted the recommendations in principle, subject to working through the detail of their financial implications.

2.2 IMPROVING ACCESS

In response to the Health Select Committee Report on Dental Services (see above) the government accepted that progress on improving access had been "disappointing to date" (*Government Response to the Health Select Committee Report on Dental Services* HM Stationery Office, October 2008).

Dentistry was included in the NHS Operating Framework 2008/09[5] for the first time, with the expansion of access to primary care dentistry from the April 2006 baseline identified as a key aim for the NHS. The document called on PCTs to *"ensure robust commissioning strategies for primary dental services, based on assessments of local needs and with the objective of ensuring year-on-year improvements in the number of patients accessing NHS dental services (as measured by quarterly data published by the Information Centre on the number of people receiving primary dental services within the most recent two-year period)".*

The government demonstrated its commitment to improving access by announcing an 11% increase in dental funding to PCTs for 2008/9. At the same time the period for ring-fencing NHS dental funding was extended by two years to the end of March 2011 aiming to provide reassurance to patients and dentists of the government's continuing commitment to NHS dentistry.

The NHS Operating Framework 2009/10[6] again identified improving access to NHS dentistry as a key priority, stating that "*PCTs need to continue to develop NHS dental services so that they meet local needs for access, quality of care and oral health. This will include reviewing dental commissioning strategies, ensuring open and transparent procurement for all significant new investments in dental services, in order to provide access to anyone who seeks help in accessing services"*.

"World Class Commissioning: Improving dental access, quality and oral health" (DH Jan 2009) was part of a series of World Class Commissioning guidance documents on primary care, produced following the final report of the NHS Next Stage Review *'High Quality Care for All'.* This noted that *"Local surveys and deliberative events consistently underline that NHS dentistry matters to the public and that it is seen as a priority to tackle the continuing problems of access to services in many areas of the country."*

[4] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101137
[5] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094
[6] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091445

The guidance identified the establishment of a well-publicised dental access helpline as a key element of a successful dental commissioning strategy, together with the need for PCTs to work with the Local Authority and the public to take account of unmet demand for services.

The Steele Review, similarly stated that noted that people are uncertain how to find a dentist and the information they require is often not available in the right places, is not co-ordinated or is not kept up to date. It noted that this was much more a matter of organisation than resource.

The Review recommended the continuation of efforts made by the Department of Health to address problems but also recommended the piloting of blended contract currencies to include an annual per patient payment to recognise the numbers of patients in continuing care.

2.3 ENCOURAGING PREVENTATIVE CARE AND REDUCING INEQUALITIES

"Modernising NHS Dentistry: Implementing the NHS Plan (2000)" flagged up the importance of a preventative approach to dentistry and gave a commitment to tackling oral health inequalities. Similarly "NHS Dentistry – Options for Change" (2002) identified prevention as a key function for a modernised NHS dental service and spoke of allowing General Dental Practitioners "for the first time, to focus on preventive measures, to combat dental disease and to tackle the serious oral health inequalities particularly in children".

The themes of an emphasis on preventative care and reducing oral health inequalities were continued throughout a series of publications around the time of the introduction of the new contract including

'Choosing Better Oral Health - an oral health plan for England'[7] (2005);
'*Valuing People's Oral Health: A good practice guide for improving the oral health of disabled children and adults*'[8] (2007);
'*Smokefree and smiling: helping dental patients to quit tobacco*'[9] (2007) and
'*Delivering better oral health: An evidence-based toolkit for prevention*'[10] (2007)

Encouraging preventative care is a core theme of the Steele Review which speaks of "making the transition from dental activity to oral health as the outcome of the NHS dental service". The review states that "just as health is the desired outcome of the rest of the NHS, so health should now be the desired outcome for NHS dentistry".

The report recommends that NHS primary care dentistry provision should be commissioned and delivered around a staged pathway through care which allows and encourages continuity of the relationship between patients and dentists for those who want it, which is built around the most appropriate recall interval for the patient and which uses oral health as an outcome.

With regard to reducing inequalities, the World Class Commissioning dental guidance

[7] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123251
[8] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080918

[9] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074970

[10] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078742

(see above) refers to a CAB/MORI survey which shows that a significantly lower proportion of non-white respondents reported having seen a dentist in the previous two years compared to white respondents. It also noted that older people and those with disabilities had received inadequate attention.

The guidance notes the need for PCTs to be sensitive to the needs of different groups in looking at how unmet demand is noted, to ensure community engagement in promoting awareness of how to access services and to ensure that help lines are able to give advice on matters such as disabled access to surgeries, interpretation services and transport links.

2.4 QUALITY

In 2008 the NHS Dental Services Division and the Department of Health devised a set of "vital sign *metrics"* to monitor key aspects of the delivery of NHS primary care dentistry. Four key areas are covered; access, activity, quality and value for money. A report is now sent to every PCT quarterly analysing the activity of their practices according to these measures. This report is one of the main sources of contract monitoring information for PCTs.

Quality is a fundamental theme of the Steele Review which notes that "while meeting local need is important, the level of variation in the quality of care is too great". The review recommends several steps to be taken at a national level to improve quality including a revised contract, clinical guidelines on thresholds for treatment and an extension of the free replacement period for restorations to three years, with the cost to be borne by the provider.

The report also recommends that at a high priority be given to developing a consistent set of quality measures and notes that this should be undertaken at a national not a local level so as not to be "a waste of resource that could be used elsewhere" for PCTs.

With regard to local commissioning the review notes that the process and skills in commissioning dental services have been highly variable. It recommends that PCTs should be required to demonstrate good organisation and structures, including in senior leadership in the PCT and strong clinical engagement.

The review addresses the role technology can play in helping to facilitate the collection and organisation of data and notes that around 25% of dental practices currently do not even have the very basic computer hardware to record what happens chair-side and link it to national datasets. It recommends that PCs are used in all dental surgeries within three years and are, ultimately, centrally connected to allow clinical data to support shared information on quality and outcomes.

3. FACTORS AFFECTING ORAL HEALTH AND THE HARINGEY DIMENSION

Many factors impact upon oral health some of which have a particular relevance to the Haringey population.

3.1 ORAL HYGIENE

Effective twice daily brushing reduces caries and improves periodontal (gum) health. Tooth-brushing practices are best learned in early childhood. The health of periodontal tissues, the mucous membrane lining the mouth, and the bone supporting the teeth can be compromised when teeth and gums are not brushed regularly and dental plaque accumulates.

3.2 DIET AND NUTRITION

Diet and nutrition are major determinants of oral health or disease. A diet high in sugary foods and drinks predisposes not only to obesity and diabetes, but is also the main cause of tooth decay. The more frequently sugars are consumed, the greater the time during which the tooth is exposed to low pH levels at which demineralisation occurs. Less frequent consumption of food and drinks containing sugar means that teeth have a chance to repair themselves. High levels of sugar intake through consumption of fizzy drinks, sweets, chocolate and processed foods causes rapid and serious dental decay.

A healthy balanced diet which is low in fat, salt and sugar is important for good health and helps prevent oral cancers. A proportion of all age groups of the population consume less than the current recommendation of at least five portions of fruit and vegetables a day.

A range of factors influence what people eat and drink including cost, availability, access and clear information.

3.3 TOBACCO

Mouth cancer is most common in people over 40 who smoke. Smoking is the greatest risk factor for oral cancer and increases the prevalence and severity of periodontal disease. Tobacco consumption can take many forms and over 90% of patients with oral cancer use tobacco in some form. Smoking 20 or more cigarettes a day increases the risk of oral cancer to six times that of non-smokers. Although less harmful than smoking, the chewing of tobacco products is also associated with an increased risk of oral cancer. So too is chewing betel. Tobacco use is also linked to a range of other oral health problems and reduces the success rates of dental treatments such as implant surgery.

3.4 ALCOHOL

Alcohol is the second major risk factor for oral cancer and for non-smokers it is the most important risk factor. When individuals drink above 30 grams of alcohol per day the risk increases linearly.

3.5 INJURY

Broken teeth can occur in contact sport, violence and falls and are common. Binge drinking can result in facial injury. Broken teeth are a common problem amongst certain groups such as adolescent boys

3.6 OTHER CONDITIONS

A range of medical conditions can adversely affect oral health. People with eating disorders, particularly bulimia may have problems with excessive tooth wear due to the acidic pH of the mouth. People with chronic diseases on multiple long-term medications can have problems with a dry mouth.

3.7 FLUORIDE

Tooth decay occurs when acid is produced by bacteria found in the plaque on the surface of the teeth which results in the loss of some of the tooth calcium and phosphate minerals. This demineralisation happens every time sugary foods and drinks are consumed. Once the plaque acid has been neutralised some of the minerals can be deposited back into the teeth – a process known as remineralisation. Fluoride tips the balance in favour of this 'repair'. Increasing the availability of fluoride can therefore help prevent tooth decay. Since the 1970s, fluoride has been added to most toothpastes and this is the main reason for the improvement in oral health seen in the UK and Europe. Effective, twice-daily tooth brushing has the additional benefit of improving periodontal health. In areas with high levels of disease, water fluoridation is an effective and safe public health measure to reduce decay and more beneficial than the use of just fluoride toothpaste alone. Estimates of fluoride concentration in Haringey water are around 0.2 - 0.3 part per million. This is too low to have much of a protective effect. One part per million is considered to be ideal.

3.8 DEPRIVATION

General Relevance

Poor oral health is closely associated with socio-economic deprivation and social exclusion. In general, caries (tooth decay) levels are higher amongst disadvantaged people. The British Association for the Study of Community Dentistry Services (cited in *Equality and Inequalities in Health and Social Care in Northern Ireland: A Statistical Overview (DHSSPS, 2004:99-100)* found that prior to the introduction of the new dental contract when a system of registration was in place, a greater number of unskilled manual workers than professionals were not registered with a dentist.

One reason for this is that social class relates to issues affecting access to dentistry, such as a perception of the unimportance of regular dental care, a perception of the high cost of dental care and anxiety about dental treatment. (*Effects of Social Class and Dental Attitudes on Oral Health, Donaldson, A.N et al (2008) J. Dental Research 87(1): 60-64.*

Poor oral health is also connected to deprivation due to diet. Research by the National Consumer Council has shown that in many deprived or socially excluded communities where low income households are concentrated there is often inadequate shopping provision with only a limited range of food available.

Smoking is also a factor - although overall rates of smoking have declined in recent decades, the habit is now increasingly confined to socially disadvantaged groups and is a major contributor to health inequalities. (Smoking and Health Inequalities: Health Development Agency, 7th March 2001)

Deprivation in Haringey

Haringey has a dramatically mixed population in relation to levels of deprivation. According to the Index of Multiple Deprivation 2007 (which measures deprivation at small

area level through a number of socio-economic criteria) Haringey is the 18th most deprived borough in England and the 5th most deprived in London. The north east of the Borough is the most deprived part, particularly White Hart Lane and Northumberland Park.

London has the highest regional level of child poverty, with 2 out of 5 children living in poverty in inner London areas, which includes Haringey (Greater London Authority (2007) Child poverty in London: 2007 update)

Employment in Haringey has risen in recent years, but levels of worklessness in the most disadvantaged parts of the borough remain high, impacting on health and well-being and life expectancy. There is a radical difference between the West and the East of the borough with regard to life expectancy. A boy growing up in Muswell Hill can expect to live 5.5 years longer than a boy growing up in White Hart Lane.

The family and family structure has a strong impact on the health and wellbeing of children and their parents. Inadequate family income is more common in single parent families, and family breakdown can also have adverse social and health consequences for children and their parents. At the 2001 census, 29.2% of households in Haringey had dependent children, similar to the London figure (29%). Haringey has a slightly higher proportion of lone parent households with children (13.6%) compared to the London average (11.1%), with a marked East/West divide. The proportion of lone parent households with dependent children is highest in White Hart Lane (17.8%), Northumberland Park (15.5%) and Tottenham Hale (15.5%), compared to Crouch End (4.2%), Highgate (4.4%) and Muswell Hill (4.4%)

3.9 ETHNICITY

General Relevance

There is also a connection between oral health and ethnicity. According to Kings College London and the Eastman Dental Institute which are part of the WHO Collaborating Centre for Disability, Culture and Oral Health, there has been improvement in the oral health of black and ethnic minority children over several decades. However, as noted in the previous chapter, the Department of Health guidance “Improving dental access, quality and oral health” (DH Jan 2009) notes that the most recent CAB/MORI survey showed that a significantly lower proportion of non-white respondents said they had seen a dentist in the previous two years compared to white respondents.

This connection may well be linked to deprivation on an ethnic basis *(“The effect of socio-economic status and ethnicity on the comparative oral health of Asian and White Caucasian 12-year-old children” Dugmore CR, Rock WP. 1: Community Dent Health. 2005 Sep;22(3):162-9)*. However other relevant factors also include religious background and the ability of the mother to speak English.

Ethnicity in Haringey

Haringey is the 5th most diverse borough in London, behind Brent, Newham, Hackney and Ealing. 37.1% of Haringey residents in 2001 were not born in the UK; almost half of these residents were born in Asia and Africa.According to the 2001 Census, 34.4% of the population of Haringey reported that they were of Black and Ethnic Minority origin (BME). In 2005, it was estimated that the largest ethnic groups in Haringey were White British (47.6%), White Other (14.1%), Black Caribbean (8.3%) and Black African (9.1%). Between 2001-05, the largest growth in Haringey was seen in the Pakistani (38.1%), Chinese (36%), and mixed White and Asian (12.5%) communities.

There is considerable variation in the geographical distribution of ethnic groups (measured by self report on the Census) across the borough. Residents of Black ethic origin tend to reside more frequently in the wards of Northumberland Park, Bruce Grove and Tottenham Green. Residents born in Cyprus tend to reside more frequently around West Green, Haringey, Bounds Green, Woodside and White Hart Lane. Residents born in Turkey tend to reside in areas of Northumberland Park, West Green and Tottenham Hale.

The most common ethnic origin of school pupils in Haringey is White British (19.9%), followed by Black African (17.9%) and Black Caribbean (13.0%). White other (10.5%), Turkish (6.8%) and Kurdish (3.2%) are also large groups in Haringey schools. There are approximately 130 languages spoken by pupils attending Haringey schools. The most common languages spoken (other than English) are Turkish, Somali, Akan, French, Polish and Bengali.

Haringey is one of the religiously most diverse places in the UK. According to the 2001 Census, which provide the most up-to-date figures on the religious profile of Haringey, half of residents of Haringey were Christian, 8.1% less than London and 21.6% less than England and Wales. 11.3% of Haringey residents stated their religion to be Muslim, 2.8% higher than London, and 8.3% higher than England and Wales. Haringey has a lower percentage of residents who stated their religion as Hindu (2.1%) and Sikh (0.3%) than London (4.1% and 1.5%, respectively). A fifth of Haringey residents stated that they did not have a religion.

Haringey has a large numbers of international migrants and attracts a relatively large number of Asylum Seekers. However, over the last 5 years the number arriving has dropped from 5,823 in March 2001 to 649 in March 2006, peaking in March 2002 at 6,032. The proportion of London's asylum seekers settling in Haringey has fluctuated over the last 5 years between 8.6% and 11.4%, although in March 2006 it dipped to 6.1%. The total number of individuals in receipt of "subsistence-only" support from National Asylum Support Service (NASS) has fallen from 1,172 in April 2005 to 734 in March 2006, representing 11.7% and 8.3% of London, respectively.

3.10 AGE

General Relevance

Tooth decay is one of the most prevalent diseases in children and young people, despite huge improvements in children's oral health. Generally, oral health in children (especially of older children) has been improving in England, but now appears to have plateaued particularly in five year olds. According to the Childrens Dental Health Survey 2003 (Office for National Statistics, March 2005) the oral health of children living in England in 2003 was better than it had been since records began and the oral health of 12 year olds was the best in Europe.

National Surveys conducted in the UK every 10 years have shown considerable improvements in the oral health of adults. More adults now keep their teeth for life. In 1968 as many as 37% of adults in England had no natural teeth but by 1998 this figure had fallen to 11%.

People are not only living longer but also retaining their natural teeth for longer into old age. It has been estimated that by 2025 there will still be 20% of older people who have no natural teeth but that up to half of all older people will have retained 21 or more natural teeth. (Ref?) Changes that can occur over time in the gum tissues expose vulnerable root surfaces to the oral environment and therefore potentially to the decay process. Thus older people's oral health is at risk of dental decay, gum disease and

tooth wear, whilst they are at increased risk of developing root decay and oral cancer. The treatment needs of older people can be complex with systemic disease and medication compounding oral risk factors, such as dry mouth. This makes oral hygiene and treatment more difficult.

The latest UK Adult Dental Health Survey (1998) found that those aged 65 years and over have more complex dental treatment needs as well as greater expectations for dental treatment. However the survey showed that only 19% of adults aged 75 and over were registered with an NHS dentist.

Age Concern England commissioned an omnibus survey of 1,097 people aged 65 or over in England in 2008 involving face to face interviews in respondents' own homes. Just over half of those surveyed had an NHS dentist but there were significant regional variations in access. In addition to problems in finding a dentist, the survey showed that some older people were not aware of the importance of regular dental care.

The oral health of frail elderly people can be affected by their diet - eating sweet snacks between meals of little nutritional value to compensate for a reduced food intake.

Age of the Haringey Population

Haringey has a similar age profile to London, with 31.6% of Haringey residents aged less than 25 years in 2006 (compared with 30.4% in London) and 22% aged between 25 and 34 years. The population aged 65 and over has declined slightly as a proportion of the total population, from 9.6% in 2001 to 9.3% in 2006. This is consistent with London, the population of which has declined over the same period from 12.3% to 11.8%.

There are approximately 55,600 children and young people under 20 living in Haringey. Wards with the largest number of people aged under 19 in Haringey are in Seven Sisters, Northumberland Park, Tottenham Hale and White Hart Lane.

The population of Haringey is expected to increase in age over the next 25 years. By 2025 the number of residents aged 10-39 is projected to fall by 6.3% (7,300 residents), while the number of those aged 40 to 69 years will grow by 26.7% (17,500 residents).

The numbers of very young children is also predicted to grow, increasing demand for many children and family services.

3.11 VULNERABLE GROUPS

General Relevance

Vulnerable groups within society often experience poorer oral health and can have more difficulty in gaining access to primary dental care services. Adults with an impairment or disability that makes diagnosis, experience or treatment of dental disease challenging are a special group at risk. People with a mental illness tend to have fewer teeth, more untreated decay and more periodontal disease than the general population.

Those in long term institutional care (including older people, people with a learning disability or mental health problem, those who are physically or medically compromised and those in secure units) are often dependant on others for their diet, personal care and access to health services. These groups are more likely to have poor oral health and inadequate or restricted access to dental services (*Commissioning Tool for Special Care Dentistry. London: British Society for Disability and Oral Health 2006.)* A relatively small proportion, though a significant number, of older people live in residential care, accounting for 5% of all older people. However, the proportion increases with age, such that 20% of people aged 85 years and over and 84% of those aged 95 and over live in

residential care (*Tinker, A. The social implications of an ageing population. Mechanisms of ageing and development. British Society for Research on Ageing 2002. 729-735).*

In Haringey as at March 2009 there were 15 homes listed by the Commission for Social Care Inspection (CSCI) as old age homes, with a total number of 425 spaces. There were nine homes registered for patients with dementia with a total number of 308 spaces and two homes registered as 'care homes with nursing' with a total of 68 beds.

Within England an estimated 210,000 people have a severe learning disability, just under one-third of whom (65,000) are children and young people. A further 1.2 million people have a mild or moderate disability (Department of Health, 2001). Within London, 20% of households include a disabled person (Greater London Authority –London GLA, 2002). Many of these disabilities are minor or moderate and would not prohibit care in mainstream services, supported by specialist backup if required.

Other vulnerable groups include those socially excluded for example through addiction (drug and alcohol), lack of educational attainment, poverty, those seeking asylum and the homeless. Drug users can experience particular oral health issues. Some specific oral and dental health problems are associated with drug use such as sugar cravings, teeth grinding and dry mouth. In addition oral health can be a low priority to addicts, and is also affected by low self-esteem and a chaotic lifestyle. There can be particular barriers to accessing care such as fear of dentists, a lack of willingness by the professional to treat users, the ability to self-medicate and a disorganised lifestyle. (*Interviews with drug users – Robinson PG et al BDJ 2005 198:219-22).*

Vulnerable Groups in Haringey

Haringey has 38 registered as care homes for adults with learning disabilities with 210 spaces. The main type of learning disability for those in this type of residential care is dementia. In addition to those in care homes there are perhaps 1000 adults with learning disabilities known to the Learning Disability Service There is little data on the oral health needs of this group of the population.

Each residential home is visited annually by a reviewing officer to carry out a person centred review of the individual's care plan. It is recognised that there is a problem maintaining a healthy diet for some of the residents and that oral hygiene is very difficult to maintain.

Severe disabilities include those with severe mental health problems; complex concurrent severe medical conditions, e.g. bleeding disorders, cystic fibrosis, complex medication, terminal illness, immuno-compromised/suppressed. complex restorative, prosthetic or treatment planning needs; and treatment under general anaesthesia in hospital.

There are ten homes in Haringey registered as nursing homes for physical disability with 211 spaces.

At the end of March 2009 there were 180 children in Haringey who were subject to a child protection plan and 464 children in care. There is a statutory requirement to assess the oral health needs of children in care but no such requirement for children subject to a child protection plan.

The University of Glasgow prevalence study (2004/5) estimated that Haringey had in the region of 2485 problematic drug users, with a rate of primary crack use above the London average and marginally higher than average rates of crack and heroin use. The Haringey Drug and Alcohol Action Team also noted high levels of poly drug use, an

upward trend in cannabis use and an ongoing but stable rate of opiate use. *(Adult drug treatment plan 2008/9 – Part 1 Partnership name: Haringey Drug and Alcohol Action Team submission to NTA: 14th March 2008*

4. ORAL HEALTH IN HARINGEY

4.1 FIVE YEAR OLDS

National surveys of children's oral health are undertaken every 10 years and local British Association for the Study of Community Dentistry (BASCD) co-ordinated surveys are undertaken more frequently. The last survey of five year olds in Haringey was carried out in 2003/4 which looked at the teeth of 2617 five year olds, 93.5% of the population.

A total of 2,617 children were examined and the proportion in each area was about equal, except in the 'Wood Green' locality where fewer children are resident.

The results were as follows:

	Decayed teeth (dt)	Decayed, missing or filled teeth (dmft)	Sound teeth	Care Index (Amount of decay that has been treated)
Haringey	0.66	1.06	18.09	22
London	1.12	1.49	17.68	17

This would appear to suggest that Haringey has a better standard of oral health than London as a whole. However, closer analysis reveals a wide variation in figures between postcode and indeed school. For example, hildren in Seven Sisters had four times more decayed teeth than those in Highgate and four times more dental disease than those in Muswell Hill.

Oral Health by Postcode

The table below shows Decayed Teeth In Five Year Olds In Haringey By Postcode:

Postcode	No. of decayed teeth
Haringey Average	**0.66**
London Average	**1.12**
N6	0.21
N10	0.22
N11	0.36
N8	0.49
N22	0.74
N4	0.74
N17	0.79
N15	0.85

The table below shows Decayed, Missing and Filled Teeth in Haringey by postcode:

Area	Number of decayed missing and filled teeth
Haringey Average	**1.06**
London Average	**1.49**
N10	0.37
N6	0.42
N11	0.65
N8	0.8
N4	1.13

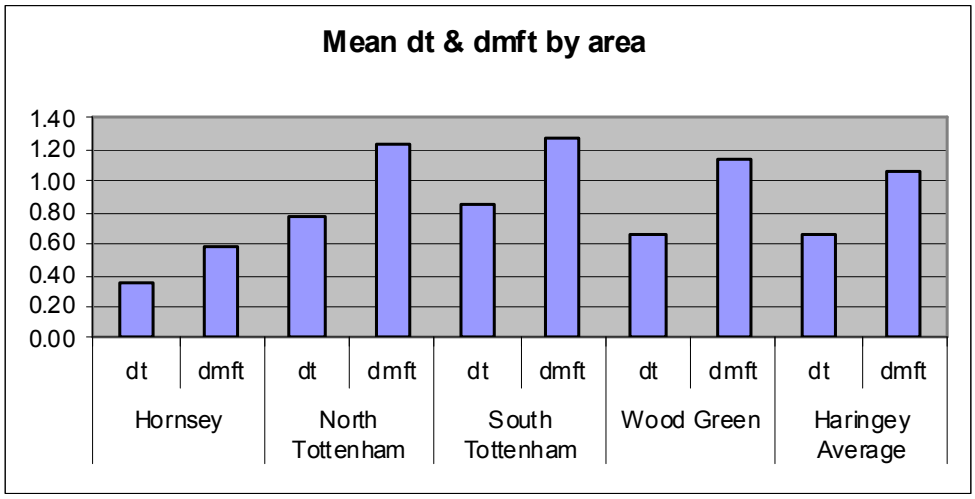
N22	1.24
N17	1.25
N15	1.29

Similarly, while the the amount of sepsis (which indicates dental neglect) was better for Haringey 5 year olds than the London average (1% compared to 2%) there was also a wide variety within the borough with some areas worse than the London average.

North Tottenham	0%
Hornsey	0.3%
South Tottenham	1.4%
Wood Green	2.4%

Variation between Schools

Within particular parts of the borough there is also a wide variation in results, even between schools. Certain schools in more deprived areas of Haringey, had children with an average dmft far in excess of the London average. Schools such as Noel Park (dmft 2.39), and Lea Valley (dmft 2.27) had results well in excess of the London average of 1.49, and Schools such as Bruce Grove (dt 1.65) had higher decay rates than in London as a whole (dt 1.12)



The area with the highest rate of decay and the worst impact of that decay was South Tottenham, the area encompassing the N15 and N4 areas of Haringey. The area with the best oral health was Hornsey. However some schools within Hornsey stand out in their level of disease such as North Harringay Primary, which has a dt level of 1.2 (worse than the national average). The higher rates of decay reflect the location of these schools in the more deprived part of that locality.

North Tottenham had the second worst rate of decay in 5 year olds in Haringey, but this was concentrated in some specific schools in particular areas of the borough. In particular Welbourne,(dt – 1.2) Risley (dt – 1.4) & Bruce Grove (dt – 1.65) showed a mean dt that was higher than in parts of South Tottenham.

While South Tottenham has the highest rate of decay in five year olds in the borough a few schools stood out as having particularly high rates of decay. The decay rate at South Harringay (dt 1.4) and West Green Primary (dt 1.5) were considerably higher than elsewhere in the locality and higher than the average for England and London (dt for both - 1.12)

Although Wood Green had the second best rate of tooth decay in Haringey, there were some specific areas of need. Noel Park School in particular had a dt rate of 1.76, the highest in the

borough, and much higher than the England and London averages. This rate was exceeded only by some areas of Newham in London, which has a poor outcome for health overall.

Untreated Decay

Comparisons between 2001/2 and 2003/4 show a fall in overall untreated tooth decay in 5 year old children in Haringey, and indeed show that overall children in Haringey enjoy better oral health than those in neighbouring boroughs. However there were areas throughout the borough where rates of decay and untreated sepsis were higher than both the London and England averages.

This appears to be accounted for by untreated decay rather than by missing or filled teeth. The rate of Care Index indicates the amount of decay that has been treated and is worse for children attending Lordship Lane than the average for the whole of Haringey. The amount of sepsis in the school (neglected severe decay that has caused abscesses) was also double that for Haringey as a whole, although not the worst in its locality.

Overall, despite having an overall better picture of child oral health than London as a whole, Haringey has pockets of deprivation and poor oral health.

4.2 TWELVE YEAR OLDS

The most recent national survey that is available is the BASCD Co-ordinated NHS Survey of 2000 2001.

2001 12 year olds	Haringey	London	England
Average no of decayed teeth (dt)	0.045	0.28	0.39
Average no of missing teeth	0.031	0.03	0.06
Average no of filled teeth	0.428	0.41	0.41
Average no of decayed, missing or filled teeth (dmft)	0.503	0.73	0.86
Average no of sound teeth	24.144	24.18	23.57
% of people with dmft >0	65%	31%	37%
% dt>0	10%	17.40%	21.30%

The data shows that by 12 years of age many of the Haringey children with active tooth decay have had that tooth decay treated.

Orthodontic treatment is unusual in comparison to other forms of dental treatment since need is not linked to deprivation. The National Child Dental Health Survey of 2003 showed that the percentage of UK 12 year olds wearing an orthodontic appliance (8%) or judged to be in need of an orthodontic appliance (35%) was consistent irrespective of school deprivation status.

4.3 ADULTS

An adult oral health survey carried out in Haringey in 1998 showed the percentage of adults with 21 or more natural teeth was 81% amongst non-manual workers, which compared with the national average of 82% from the 1998 National Adult Oral Health Survey. However the percentage for manual workers was 66% which was significantly below the national average.

There is no local probability-sampled epidemiological data available on the oral health of adults in Haringey after 1999. Due to funding cuts in the PCTDS Haringey is not in a position to take part in the National 2009 Adult Dental Health Survey (see later in relation to current services). Section 3.10 above looks at the age-related factors on oral health and considers the age profile of the Haringey population. Some inferences can be drawn from this.

4.4 OLDER PEOPLE

There is very little recent systematic epidemiological data available on the prevalence and distribution of oral diseases in older people in Haringey.

5. BEST PRACTICE

5.1 IMPROVING ACCESS

World Class Commissioning: Primary Care and Community Services: Improving dental access, quality and oral health" (Jan 2009) states that PCTs that have been fastest in seizing the opportunities of local commissioning have shown that they can improve access and quality . Some parts of the country have increased the number of people using NHS dental services by up to 24% (Isle of Wight PCT) and 17% (Medway PCT). Both PCTs employed a strategy of increasing the workforce, undertaking a reconfiguration of services, instigating further targeted oral health promotion and introducing support for training and recruitment.

There have been no well-designed studies to show the most effective way of improving access. There has been no definitive research into costs and their impact on access.

The 2009 guidance above notes that an important way of assessing and meeting unmet demand is to have in place a well publicised dental access helpline, both for people seeking urgent care and those seeking help in finding a regular NHS dentist. The help lines should be able to give advice, for instance, about disabled access to surgeries, interpretation services, transport links etc. PCTs are advised to work with patient groups to agree the information that is most useful to local people in understanding the relative merits of different practices, eg details on location, car parking and transport, opening hours including availability of urgent access slots, consultation language, child friendly facilities, choice of male or female dentist, services offered including access to special expertise, patient satisfaction score, and quality ratings.

The guidance also recommends effective marketing and community engagement to promote awareness of how to access services. The public should have a central role in the design and delivery of services.

Tower Hamlets PCT has produced information precisely matching the above criteria and made it available in several formats: helpline, on-line, leaflets, posters, and recently by mobile phone text. The information identifies available practitioners, costs of treatment with a clear explanation of the costs by UDA banding, charge exemptions and what an individual can expect from a dentist. Also provided is information on each practice, the nature of services, opening times, urgent and out of hours treatment availability etc. At Christmas and New Year information is also provided concerning practice opening hours and availability over the holiday season.

It is recognised that in the future the number of people who have lost all their natural teeth will decline. In 20 years time it is estimated it will have fallen to 20% of people over 65. Over a similar period of time the percentage of people over 65 who have a functional dentition (21 or more natural teeth) will increase to between 40% and 50%. The people who have all these teeth will have grown up in a period of high decay rate. Although they have retained their teeth, many will be heavily restored and these teeth are likely to require high levels of maintenance. This will have an impact on the type of dental service required and the appropriate care setting.

While basic denture work and some simple conservative and preventive procedures maybe undertaken with the appropriate equipment, in a domiciliary setting, more advanced procedures and extractions will require full surgery support. Dependent on

the environment and the numbers requiring the service this may be provided through a mobile dental surgery or by transporting individuals to a local dental surgery.

The British Society for Disability and Oral Health has developed helpful standards for domiciliary care services with associated guidelines and recommendations. These guidelines recognise the knowledge, skills and training issues required by the team who are to deliver the service, and provide useful information concerning visit planning, necessary equipment, lifting and handling and conformity to legislation.

5.2 ENCOURAGING PREVENTATIVE CARE AND REDUCING INEQUALITIES

All practitioners are expected to adopt the Department of Health's evidence-based prevention toolkit within their own practice. However there is still a need for a public health approach in the community. A number of PCTs have used the flexibilities in the new system to commission targeted preventative programmes to address oral health priorities (eg Bradford and Airedale, Salford, Manchester and Nottingham) and aim to narrow inequalities. In Bradford and Airedale PCT, an oral health action plan was developed, agreed and commissioned in association with stakeholders. The preventive/oral health promotion element was focussed around the use of fluorides, oral health training for carers, and oral health support with outreach teams who worked with vulnerable groups.

Salford PCT in association with the North Western and Mersey Postgraduate Medical and Dental Deaneries, took advantage of the new General Dental Council guidelines to permit the use of extended duty dental nurses in applying fluoride varnish (an evidence based procedure) to children's teeth in clinically supervised programmes. This approach is considered ideal in areas of persistent high caries rates.

In the Manchester area there is a dental team of 11 people for prevention, with just one dentist and a good use of skill mix. They use a traffic light system to stream individuals through a variety of care programmes following assessment.

Nottingham PCT, following the successful evaluation of the Tower Hamlets scheme, commissioned a mobile dental unit to provide services in areas where there were vulnerable and hard to reach groups who found it difficult to access mainstream services. Their service provides screening as well as urgent/short courses of treatment with a focus on health promotion and the provision of preventive services.

Although small in number compared to the whole population, addressing the needs of vulnerable groups is an additional way of narrowing oral health inequalities. A number of PCTS have prioritised the assessment and treatment of vulnerable groups. In contrast with practice in England, the Welsh Assembly has made vulnerable groups a top priority and they have ensured that local health authorities dental services provide a targeted outreach programme.

Every PCT will be different but action areas may include:

- Targeting georgraphical areas with poor oral health
- a stronger focus on commissioning preventive services
- developing a greater range of specialist services in community settings (e.g. Nottingham PCT has developed a service to patients in residential care consisting of an assessment, treatment and referral service

<u>Dentists with Special Interests</u>

Many PCTs have moved to commissioning primary care dental services from dentists with a special interest. These practitioners, following the requisite training, are able to provide services in such areas as endodontics, periodontics, oral surgery and paedodontics. Such services when appropriately commissioned can reduce referrals to the secondary care sector thereby not only reducing costs but hospital waiting lists also. They also enable the PCT to commission a full range of dental services to their population.

5.4 IMPROVING QUALITY

Scorecards developed so far to assess quality measures consider aspects of quality from three perspectives the patient, the environment and governance. They also review access, workforce, activity, finance and planning.

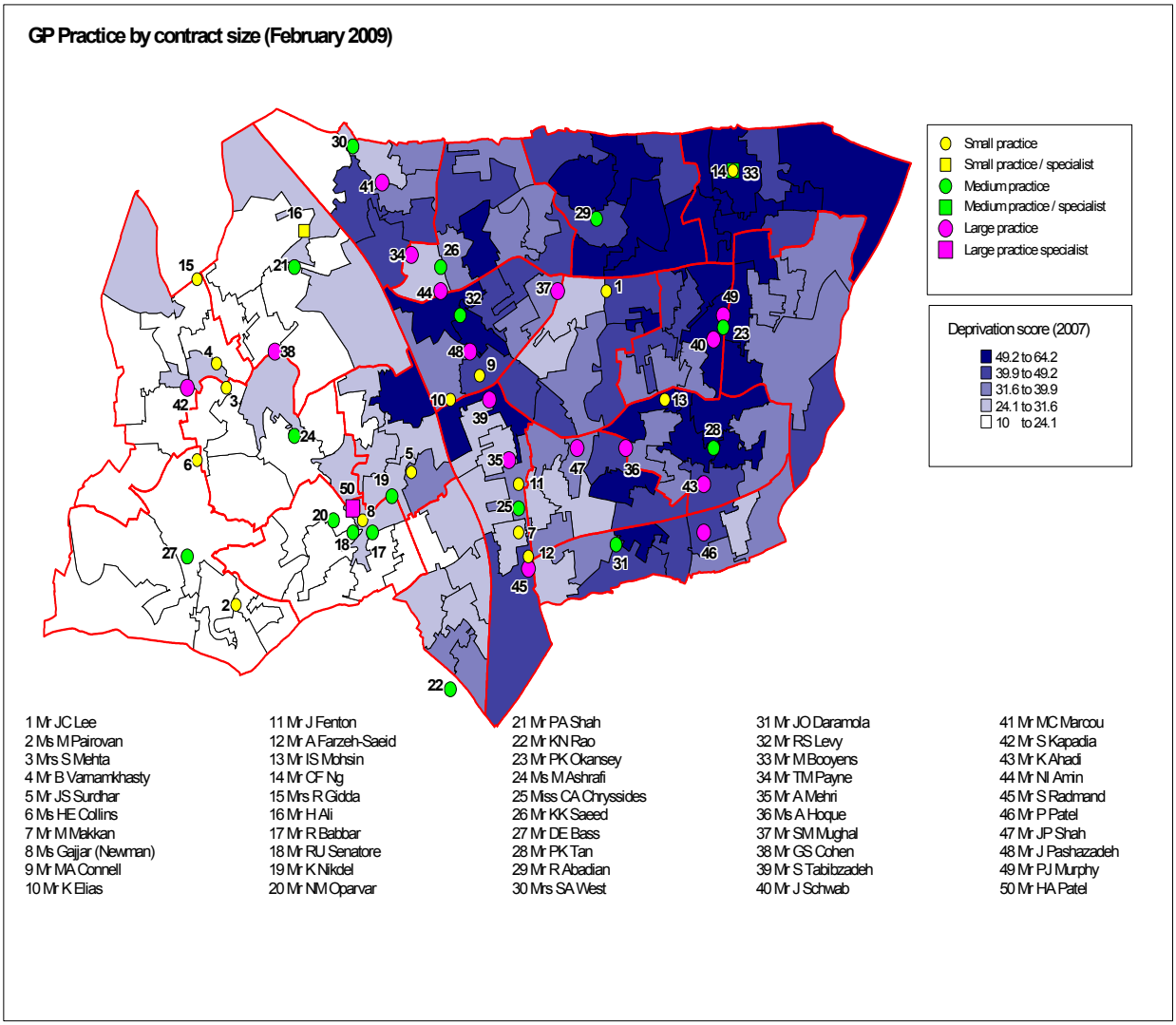
Support that PCTs offer practices in maintaining high standards may include: sharing best practice from elsewhere, establishing local learning networks across practices or brokering support from external support services. Tower Hamlets PCT in association with their LDC have developed local networks with their dental practitioners to share best practice. They are also involved with the development of quality scorecards.

The British Dental Association's (BDA) good practice scheme is considered a good starting point in developing a quality framework. It is recognised that with the development of such a system there would need to be a reward built in for its successful implementation.

6. CURRENT SERVICES

6.1 GENERAL DENTAL SERVICES

Haringey TPCT has contracts with 48 practices providing general dental services as well as contracts with a specialist sedation practice and a specialist orthodontic practice. There is a wide range in the size and type of dental practices that provide NHS dentistry. Most practices that provide NHS dentistry also provide private treatment. The number of surgeries per practice ranges from one to five. There are a number of single handed practices while the largest practices in Haringey have up to eight dentists working from the practice (some on a part time basis). The location of practices across Haringey is shown below.



6.1.1 PREMISES

Haringey's dental practices are located in a wide range of premises most of which were not purpose-built and many of which are converted residential properties. Many are above shops.

Accessibility

As at April 2008 approximately half of practices had good wheel chair access and approximately a quarter had disabled toilet facilities. A premises audit is planned by for

2009/10 to look at compliance with the Disability Discrimination Act.

Infection control

An infection control audit of all general dental practices was carried out by the PCT in 2008/9. As well as identifying several practices who were failing to meet basic standards, the audit also identified some broad themes that give cause for concern, notably that

- Decontamination knowledge and practices are poor. Four training sessions for GDP'S and their staff are planned for 2009 to address this.
- A large proportion of practices have inadequate cleaning arrangements for the premises. In most cases cleaning is undertaken by the dental nurse.
- In many cases inadequate investment has been made by practices in providing a clean clear space for decontamination of instruments.
- Cost saving strategies by contractors are in some cases compromising infection control.

Computerisation

As at April 2008, 46% of Haringey dental practices are fully computerised; (ie for patient records as well as for processing claims) 30% are partially computerised (ie either only for patient records or only for processing claims) and 24% are not computerised.

6.1.2 WORKFORCE

As at 28th April 2009 there were 135 dentists working in Haringey - 83 men and 52 women.

The total work force in Haringey dental practices as at March 2009 (ie dentists, dental nurses, receptionists and other staff) was 322 with the number of staff per practice ranging from 2 to 16.

6.1.3 COST

Dental funding is allocated to the PCT from the Department of Health annually. The amount allocated is net of the sum that it is assumed the PCT will collect in patient charges (based on a calculation of what the PCT would have collected in patient charge revenue during the reference period if the current system had been in place).

In 2008/9 £13,985,994 was spent on primary care dental contracts, which included an orthodontic contract of £1,043,745 and a contract with a sedation practice for £751,789. 458,005 UDAs were commissioned and 17,730 Units of Orthodontic Activity (UOAs). In 2008/9 the PCT invested £440,522 more in dentistry than in 2007/8. This was paid for from the 11% national increase in the dental allocation for 08/09 that was announced in the 2008/9 NHS Operating Plan. (See Chapter 2). Of the increased spending £132,000 was spent on capital funding for new equipment. The remaining £308,522 commissioned extra activity.

6.1.4 ACCESS

Dental provision in Haringey is good compared to other areas of London. Haringey ranked 7th out of the 31 London PCTs for the percentage of the population who said they were able to visit a dentist regularly as an NHS patient if they wanted to (The 2008 National Patient Survey).

Percentage of Population who said they were able to visit a dentist regularly as an NHS Patient if they wanted to (National Patient Survey 2008)

Hillingdon PCT	62.06
Enfield PCT	56.87
Havering PCT	56.69

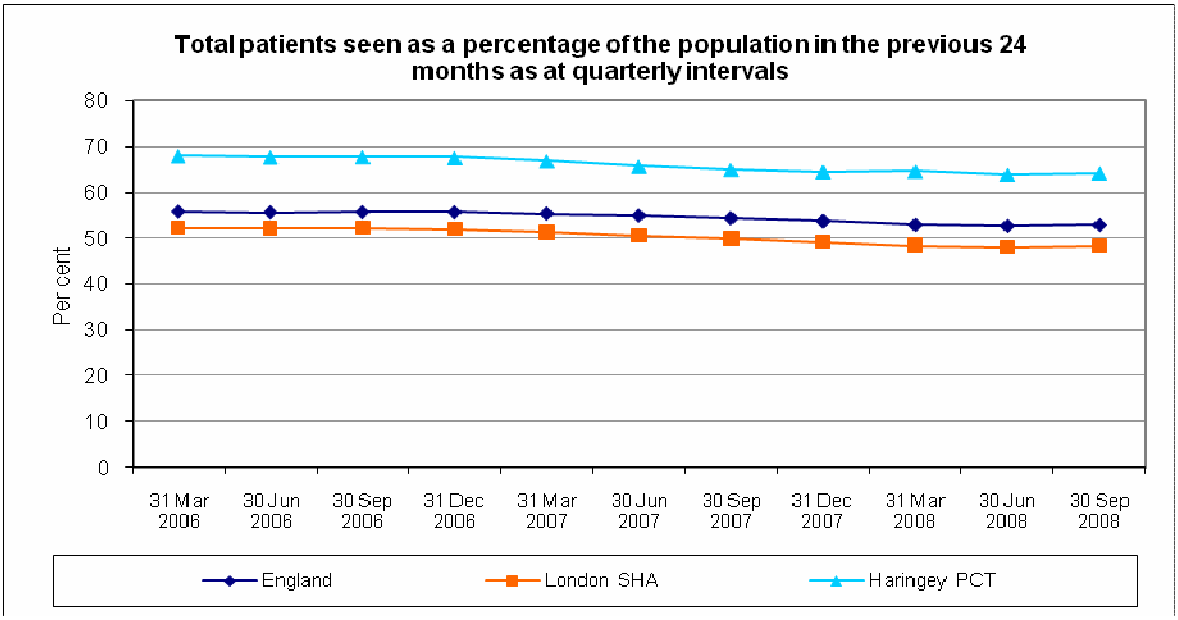
Redbridge PCT	56.18
Sutton and Merton PCT	55.69
Harrow PCT	55.60
Haringey Teaching PCT	54.51
Newham PCT	53.70
Barnet PCT	53.20
Croydon PCT	52.97
Lambeth PCT	52.80
Barking and Dagenham PCT	52.45
Lewisham PCT	51.44
Ealing PCT	50.61
Brent Teaching PCT	50.48
Hounslow PCT	49.96
Greenwich Teaching PCT	49.95
City and Hackney Teaching PCT	49.78
Waltham Forest PCT	49.77
Islington PCT	48.69
Tower Hamlets PCT	48.19
Hammersmith and Fulham PCT	48.01
Kensington and Chelsea PCT	45.15
Bexley Care Trust	44.17
Southwark PCT	43.02
Wandsworth PCT	42.90
Bromley PCT	42.54
Camden PCT	42.18
Westminster PCT	39.73
Kingston PCT	38.00
Richmond and Twickenham PCT	31.24

Similarly the proportion of the population who use NHS dentistry is high compared to other areas of London. Haringey ranked in joint sixth place among London PCTs for the percentage of respondents in the 2008 National Patient Survey in Haringey who said that they visit a dentist regularly (ie at least once every 2 years) as an NHS patient.

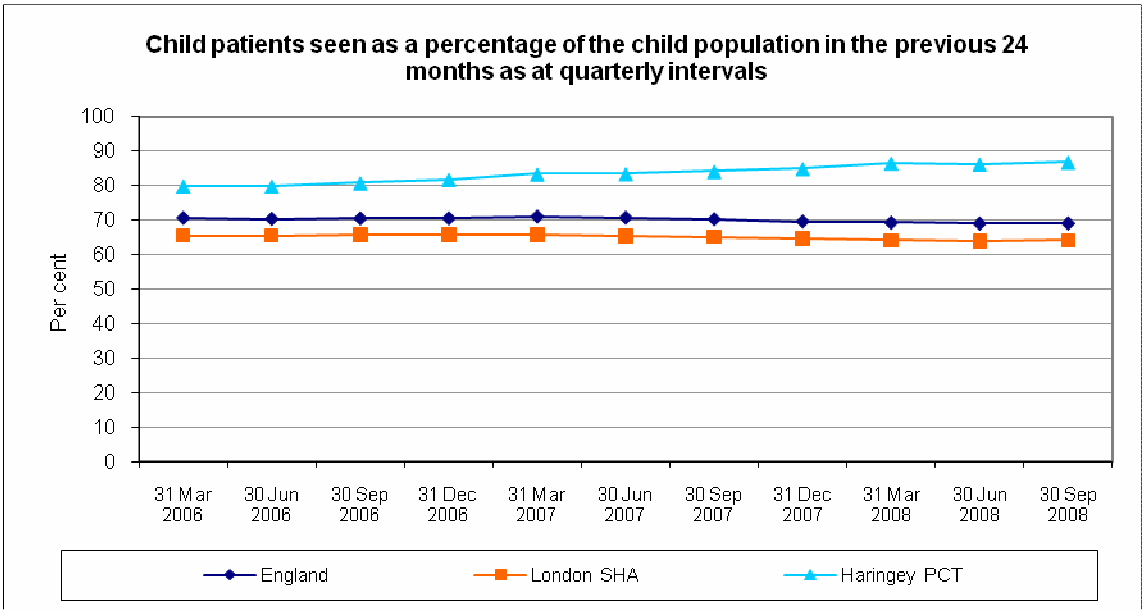
Percentage of respondents to 2008 National Patient Survey who visit a dentist regularly (ie at least once every 2 years)

	Yes - as an NHS patient	Yes - as a non-NHS patient	No
Hillingdon PCT	55	21	24
Havering PCT	51	25	24
Harrow PCT	51	22	28
Enfield PCT	50	19	31
Redbridge PCT	50	22	28
Sutton and Merton PCT	48	25	27
Haringey Teaching PCT	47	21	32
Croydon PCT	47	25	28
Barnet PCT	46	28	25
Barking and Dagenham PCT	46	11	43
Lewisham PCT	45	20	35
Waltham Forest PCT	45	20	34
Newham PCT	45	13	42
Greenwich Teaching PCT	45	20	35
Lambeth PCT	44	20	36
Brent Teaching PCT	44	18	38
City and Hackney Teaching PCT	44	19	37
Ealing PCT	44	22	35
Hounslow PCT	44	24	33
Islington PCT	43	26	31
Hammersmith and Fulham PCT	41	30	29
Bexley Care Trust	40	32	28
Tower Hamlets PCT	39	18	43
Wandsworth PCT	39	32	29
Southwark PCT	39	19	43
Bromley PCT	36	39	25
Camden PCT	34	34	31
Kingston PCT	34	41	25
Westminster PCT	33	43	24
Kensington and Chelsea PCT	33	40	27
Richmond and Twickenham PCT	26	53	21
ENGLAND	**50**	**24**	**26**
LONDON SHA	**43**	**26**	**31**

Access to primary care dentistry is measured nationally by counting the number of unique patients receiving NHS dental care over a two-year period. The number of patients seen by dentists has declined nationally and in London since the introduction of the new contract. This is also the case in Haringey, although the percentage of the population seeing a dentist is consistently above both the national and the London levels as seen below.



In contrast to both the national and the London trend, the number of child patients as a percentage of the child population seeing a dentist has increased steadily in Haringey since the introduction of the new contract, in contrast to the position nationally and in London.



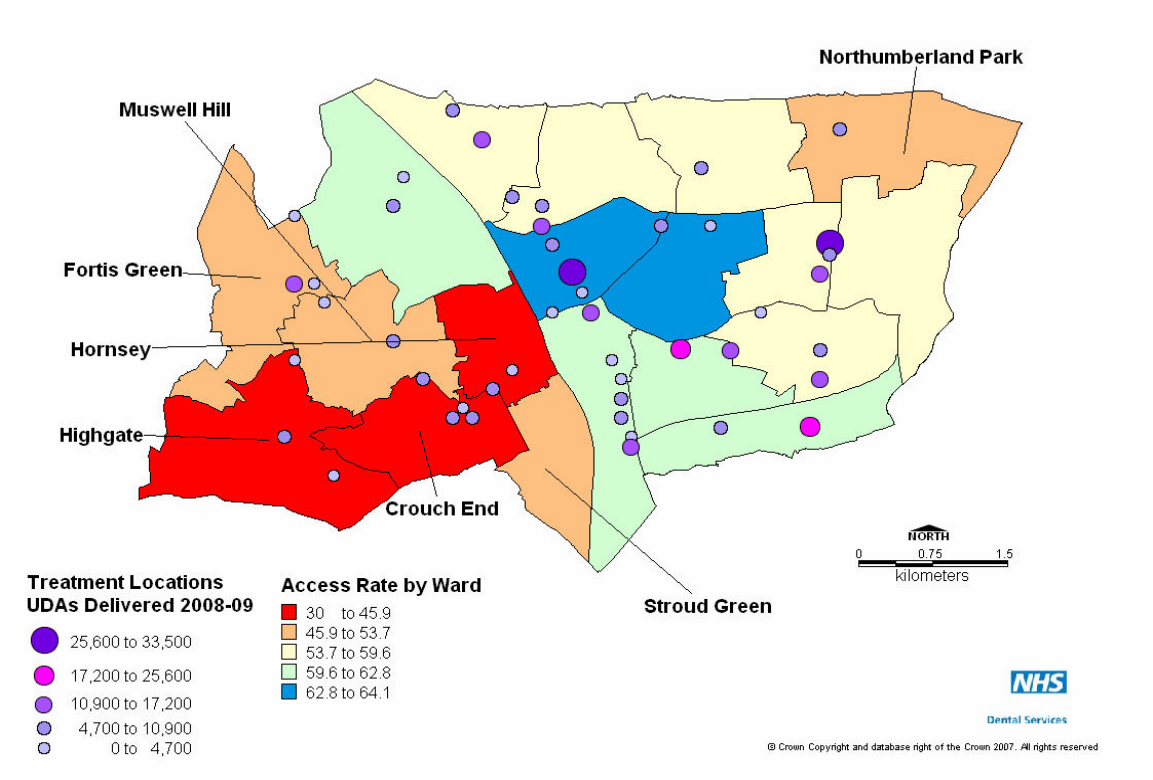
A dental access helpline number was established in May 2009 to help residents find their nearest dental practice and to provide information about practices with disabled access. However the number of calls to the service to date has been very small.

ii) Uptake and Deprivation

The number of UDAs carried out in an area does not correlate to the level of deprivation of the area (as one might expect given the link between deprivation and dental disease).

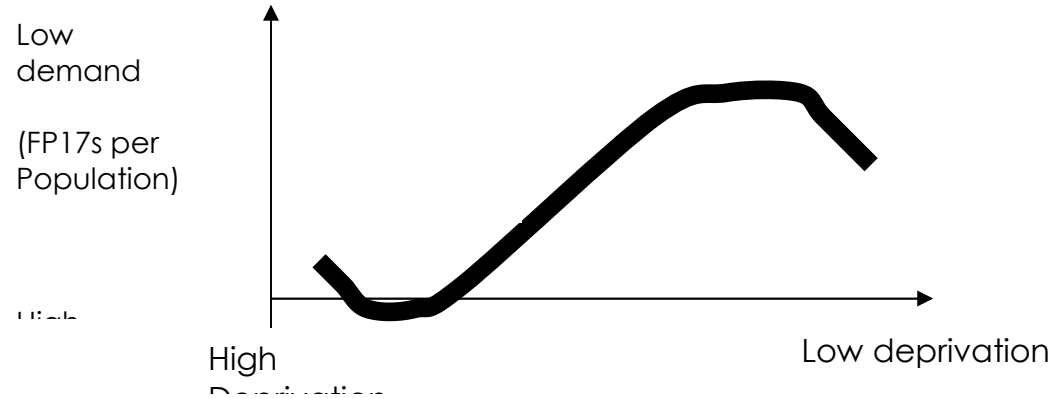
The disparity is most marked in Northumberland Park –one of the most deprived areas of the borough but which is on the second lowest level of UDAs carried out in the period.

Treatment Locations and Ward Level Access Rate (%) 2008-9



An analysis of dental treatment forms (FP17s) for patients with a Haringey residential postcode visiting an NHS dentist over a 2 month period. (January - February 2008) similarly noticed a complex relationship between demand and deprivation. This appeared to be true for adults, children and those aged 65+.

While there was a broad correlation between deprivation and demand in some areas, areas of highest deprivation appeared to show less demand for NHS dental care while demand for NHS dentistry appeared greater in areas of least deprivation. This is represented on the diagram below.



Analysis of deprivation/ demand by Area

Electoral Ward	Level of Deprivation by Rank	Demand by Rank
Northumberland Park	1	12
White Hart Lane	2	9
Tottenham Green	3	4
Seven Sisters	4	1
Tottenham Hale	5	10
Bruce Grove	6	6
Noel Park	7	2
West Green	8	3
St Ann's	9	5
Woodside	10	8
Bounds Green	11	7
Harringay	12	13
Hornsey	13	15
Stroud Green	14	17
Crouch End	15	18
Highgate	16	19
Fortis Green	17	14
Muswell Hill	18	16
Alexandra	19	11

Language/Interpreters

There are approximately 130 languages spoken by pupils attending Haringey schools (Joint Strategic Needs Assessment for Haringey 2008, Chapter 2). A small survey of interpreter needs was sent to 68 Haringey dentists in 2004. 24 of the 27 dentists who completed the questionnaire reported considerable interpreter needs. The languages that were most often in need of translation were Turkish, Somali, Greek and Russian. 36% said that they needed a telephone interpreter service; 46% needed a face to face interpreter service; 10% needed a deaf-sign language service and 8% also needed translation.

Domiciliary Visits

The number and location of visits are largely based on activity before the new contract came into effect. Therefore some of these visits are to patients/care homes outside Haringey. Two Haringey GDPs are contracted to carry out a significant number of domiciliary visits while others are contracted to carry out a small number.

6.1.5 ACTIVITY

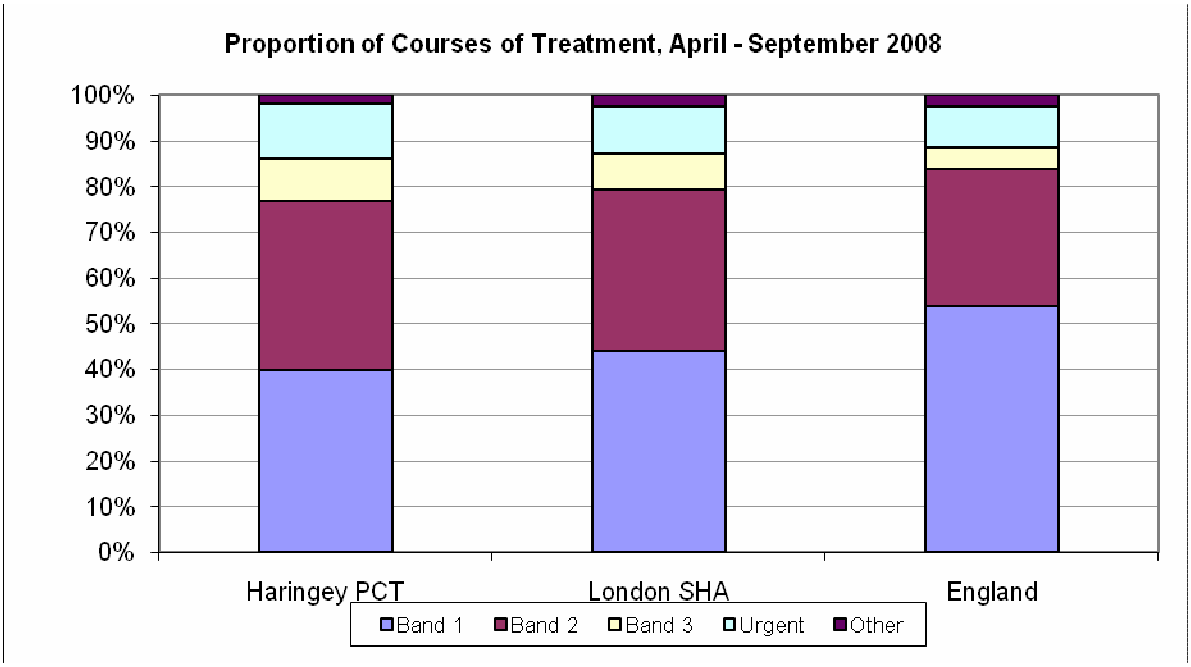
Patient Satisfaction

Patient Satisfaction with Haringey dentists appears to be lower than the average figures for London. The quarterly Vital Signs Report for March 2009 reported that 84.3% of patients with Haringey dentists were satisfied with the dentistry they had received and 78.2% were satisfied with the time they had to wait for an appointment. These figures compared to figures for London of 86.4% and 80.6% respectively.

Nature of Activity

Under the system introduced in April 2006, Band 1 covers a check-up and a scale and polish, Band 2 covers Band 1 work and fillings, root canals and extractions and Band 3 covers Band 1 and 2 work and crowns, dentures and bridges.

Haringey appears to have a different pattern of treatment than the national and London position, with a lower percentage of Band 1 treatment and a higher percentages of both Band 2 and Band 3 treatments. It also has a greater percentage of urgent treatment than either the London or England averages.



(Note - Other treatment includes arrest of bleeding, bridge repairs, denture repairs, removal of sutures and prescription issue).

6.2 ORTHODONTIC TREATMENT

In 2000 the then Enfield & Haringey Health Authority was among the highest 10% of Health Authorities in relation to the volume of orthodontic claims per 1000 local children, and in the top 2% for quality of fixed appliance treatment. (Dental Practice Board GDS statistics April 1999 – March 2000).

Haringey has a contract in excess of a million pounds with Angle House Orthodontic practice – a large orthodontic practice based in Crouch End which was established in 1989. The practice has 3 full-time dentists and is part of a group that also has practices in Edgware, Enfield and Edmonton.

The contract is for 16,907 Units of Orthodontic Activity which represents the treatment of approximately 800 patients a year (on an assumption that the average course of orthodontic treatment attracts 21 UOAs .

In addition to the service provided by Angle House, one of Haringey's general practices (Park Vue practice which is based in Wood Green) carries out a small amount of NHS Orthodontic work for patients of the practice.

Access

NHS orthodontic treatment is only available to patients who qualify on the basis of their score on an Index of Treatment Need (IOTN). Where the criteria are not met patients are referred back to their GDP. In 2007/8 2032 patients received NHS Orthodontic treatment at the practice and 267 patients were refused treatment.

In addition to the service provided by Angle House, some orthodontic treatment is provided in a hospital setting. (See section below on Hospital Dental Services).

6.3 SEDATION

NHS Haringey has a large contract with a specialist sedation practice on Tottenham High Road which sees patients referred through GDPs. The service is intended to provide general dental treatment under sedation to patients who are not able to have that treatment under local anaesthetic due to the psychological needs of the patient (e.g phobia) or the physical needs (e.g. gag reflex).

The practice uses a range of sedation techniques which includes intravenous sedation, in some cases using a combination of drugs. The practice has 3 dentists and sees about 52% children and 48% adults.

At present there is no referral management service to assess the appropriateness of cases referred to the practice, although the practice itself sees patients for an intial assessment before treatment. As well as the service provided by this practice treatment under sedation is also provided at secondary care level (see later section on hospital services). Some GDPs may be referring patients for hospital treatment where they would be more appropriately treated in a primary care setting. The cost of treatment under sedation in a hospital setting is considerably higher – some times as much as eight times the price.

About 65% of the patients of the practice reside in boroughs other than Haringey. There is a big discrepancy in the number of referrals per practice. A review of one month's activity showed 400 referrals from 130 separate dentists but some practices had many referrals. This was not necessarily in proportion to the size of the practice. This indicates the possibility that some dentists may be using the service inappropriately and referring for sedation rather than investing the time needed to be able to treat the patient under local anaesthetic.

6.4 THE PCT DENTAL SERVICE (PCTDS)

(This service was previously known as the Community Dental Service and is sometimes referred to as the Salaried Service.)

Department of Health guidance on Salaried Primary Dental Care Services (March 2006), states that the role of these services should be determined by local commissioning decisions, but have important roles in relation to

a) delivering dental public health programme
b) providing dental care for patients who, because of disability, have a need for specialised dental care
c) providing general primary care dentistry for patients of all ages:
d) providing specialised dental services as required locally, for example general anaesthesia in a hospital setting, or orthodontics.

The PCTDS is a shared service between Enfield and Haringey PCTs with two clinics in Haringey and two in Enfield as well as general anaesthetic clinics at the North Middlesex Hospital and Chase Farm.

The total budget for the PCTDS across Enfield and Haringey for 2008/9 was £2,044,125 of which some expenditure related solely to each borough, while some services (such as the general anaesthetic clinic) were run jointly. The financial split is broadly equal between the two boroughs.

The PCTDS has 11 whole time equivalent (wte) dentists, 2 wte oral Health promoters, 1 wte project staff funded by the Local Authority, 15.4 wte dental nurses and 2.5wte clerical staff. There are currently 1.4 wte dentists vacancies.

The clinical team comprises a Clinical Director and Specialist in Dental Public Health, a Senior Dental Officer and Assistant Clinical Director, a specialist in Paediatric Dentistry and Specialist in Periodontics, a Specialist in Paediatric Dentistry, a Senior Dental Officer and Specialist in Surgical Dentistry, 3 Senior Dental Officers and a Dental Officer.

In 2006/7 funding of the PCTDS in Haringey was cut by 25% which resulted in the loss of a 0.4 whole time equivalent dental nurse who gave administrative support to the school screening/survey in Haringey and the loss of a 0.4 whole time equivalent vanancy for a special needs dentist to see St Ann's Hospital inpatients of mental health, learning disability and older people's services.

Specialised Dental Care

The PCTDS accepts referrals from Health Professionals, GPs or GDPs for specialised dental care for patients with one or more of the following:

- Severe physical or medical disabilities
- Severe learning difficulties
- Severe mental illness
- Complicated dental treatment needs (e.g. Complicated medical histories, syndromes, medical regimes)
- Medically comprised people with blood borne virus's that cannot be inoculated against
- Housebound
- Terminally ill

This group accounts for approximately 1.5% of the population.

Patients can be accepted for assessment only , emergency care, short-term care for a specified procedure (e.g. GA extractions), transitional Care – e.g. while patient is resident short term as an in-patient in Haringey or Enfield, or continuing care.

In 2007/8 the service carried out 3,627 courses of treatment on 2,725 patients across Enfield and Haringey. Of those treated, 63% were children (1, 652).

Only Haringey or Enfield residents are seen by the service which does not provide any private treatment. Waiting lists for outpatient appointments at PCTDS clincs are below eight weeks. In the PCTDS-run general anaesthetic clinics the service aims to comply with the 18-week time limit. Minimum waiting time is 3-4 weeks for domiciliary visits.

Patients Who Cannot Access General Dentistry

The PCTDS carries out domiciliary dental visits to housebound patients referred by a health profession to assess whether they meet the criteria for treatment by the service.

Criteria for treatment are set locally and require the patient to meet a certain score on a national scale devised by the BDA that looks at factors such as medical status, level of co-operation, ability to communicate and mobility. In order to qualify for treatment at a domiciliary visit from the PCTDS a patient must have moderate to extremely complex treatment needs.

In 2008/9 the service carried out 396 visits to 67 housebound adults. (This figure includes visits for assessment as well as visits for treatment). Certain treatment can require multiple visits to a patient, such as dentures which can require as many as six visits.

The minimum waiting time is 3-4 weeks for domiciliary visits.

Public Health Programmes

The PCT Dental Services Directions (2006) state that a PCT shall provide, or secure the provision of oral health promotion programmes, school inspections and oral health surveys to the extent that it considers necessary to meet all reasonable requirements within its area.

The PCTDS has an Advanced Oral Health Practitioner for Haringey and one for Enfield. The service has an Oral Health Promotion Strategy for Haringey Children for 2008-2013, which identifies 5 areas of work:

- Prevention of dental disease in children
- Increase the uptake of dental services
- Develop care pathway for children
- Providing needs assessment
- Provide training to those involved with care for children

A number of programmes are identified in the strategy. These include the following:

i) Tiny Teeth Programme - a programme for pre-school children, which aims to improve the oral health of the under fives in Haringey, to increase access to NHS dental practices and to decrease decay in children aged 0-5. The programme originally grew out of the Sure Start project and was based in N15 and N17 where children's oral health had been found to be particularly bad. A number of "child –friendly" dentists were part of the programme, working to improve access for young children with high need.

ii) The Oral Health and Health Eating Programme - a programme for Year 3 children in all Haringey Primary Schools to promote good oral health and nutritional habits, to provide oral health information and to provide oral health information and support to teachers.

iii) To Care is To Do Programme - a programme to improve educational engagement and health outcomes for vulnerable children in Haringey primary schools by providing orpportunities for participants and their families to take part in sporting and other health related activities.

iv) Ante/Post Natal Groups / Family Learning /Community Groups – a programme to encourage parental behaviour change to bring about improvements in the oral health of children and to increase the uptake of dental services

The PCTDS is also responsible for carrying out local screening and oral epidemiology. National surveys of children's dental health are undertaken every 10 years and local British Association for the Study of Community Dentistry (BASCD) co-ordinated surveys are undertaken more frequently. The last survey of five year olds in Haringey was carried out in 2003/4 and the next one is due to take place in 2011/12. A survey of 12 years olds oral health is being carried out in 2008/9 however due to staff shortages the survey will not be carried out in Haringey.

The cut in PCTDS funding in 2006/7 meant that the service reduced screening/survey activity in schools to a maximum of three times in a child's school life.

6.5 HOSPITAL DENTAL SERVICES

Referrals to hospital for dental treatment for patients with Haringey GPs were as follows for 2006/7 (the last year for which we have full accurate data).

	Activity	Cost
Oral surgery	4,048	731,428
Restorative dentistry	2,840	37,224
Paediatric dentistry	1,278	106,294
Orthodontics	3,060	271,326
Maxillo-facial surgery	1,774	324,045
Oral and maxillo-facial surgery	32	24,403
Total	**13,032**	**£1,494,721**

The table below shows Elective Day Cases And Elective Inpatients for 2006/2007

	Elective –daycase		Elective –inpatients	
	Activity	Total value	Activity	Total value
Oral Surgery	329	£247,742	37	£49,078
Restorative Dentistry	63	£36,458	1	£766
Paediatric Dentistry	129	£105,706	1	£588
Orthodontics	1	£369		
Maxillo-Facial Surgery	39	£29,557	58	£89,963
Oral & Maxillo Facial Surgery	15	£11,939	8	£6,128
Total	**576**	**431,771**	**105**	**146,523**

The table below shows Non-Elective/Emergency Cases for 2006/7

	Non Elective Emerg Short Stay		Non-Elective Emerg		Non-Elective Other	
Specialty name	Activity	Total value	Activity	Total value	Activity	Total value
Oral surgery	2	£989	58	£106,311		
Restorative dentistry						
Paediatric dentistry						
Orthodontics						
Maxillo-facial surgery			41	£68,857	2	£1,340
Oral & maxillo facial surgery	1	£501	3	£3,218	1	£2,618
TOTAL	**3**	**£1,490**	**102**	**£178,386**	**3**	**£3,958**

The table below shows Outpatient First Appointment and Follow-Up for 2006/7

		OP-First		OP-Follow-up			
Specialty code	Specialty name	Activity	Total value	Activity	Total value	Total activity	Total value
140	Oral Surgery	1,733	£211,009	1,889	£116,299	4,048	731,428
141	Restorative dentistry	616	£0	2,160	£0	2,840	37,224
142	Paediatric dentistry	315	£0	833	£0	1,278	106,294
143	Orthodontics	244	£52,336	2,815	£218,621	3,060	271,326
144	Maxillo-facial surgery	486	£60,604	1,148	£73,724	1,774	324,045
145	Oral & maxillo facial surgery	3	£0	1	£0	32	24,403
Grand Total		3,397	£323,949	8,846	£408,644	13,032	£1,494,721

Referrals for oral surgery comprises the largest area of hospital referrals for patients with Haringey GPs. The significant majority of referrals for oral surgery were to Chase Farm Hospital. Other significant providers were Guys, Hammersmith, Kings, UCLH and Whips Cross. There can be a significant wait for minor oral surgery at Chase Farm Hospital. Some of the minor oral surgery work that is referred to hospitals could be performed in a primary care setting.

The PCT has therefore established an intermediate minor oral surgery pilot programme which is due to begin in mid July which will provide oral surgery for appropriate cases under local anaesthetic. An oral surgeon will provide the service one afternoon a week at a large dental practice based in Wood Green and will see cases that have been selected through a triage process carried out at the Specialist Clinical Assessment Service run by NHS Enfield. The service will initially treat approximately 5 patients a week but the capacity will be reviewed after 3 months. The intention is to introduce a substantive service after six months provided that the pilot is successful.

The hospital orthodontic service is intended for patients who require a multidisciplinary team, for example, where there is jaw work or cleft lip. It is possible that some of the treatment referred to hospitals could be undertaken by the PCTs Orthodontic Practice.

It is likely that some of the work that is currently carried out under sedation in a hospital setting could be carried out by the sedation practice.

A restorative consultant visits Chase Farm Hospital to give diagnosis and to provide treatment plans but does not provide treatment.

6.6 OUT OF HOURS

When the new dental contract came into effect responsibility for Out of Hours Care passed to the PCT. Previously this was with each dental practitioner.

NHS Haringey commissions Camidoc to provide an Out of Hours urgent dental helpline, In 2008 there were 741 contacts with this service. Of these 431 received telephone advice, 261 attended Camidoc for a face to face consultation with a GP, in 66 cases patients were referred to a dentist (either a Haringey GDP during normal opening hours or to the Sunday urgent care service) and in three cases the patient was visited at home.

A 3 hour urgent care service is provided on Sundays and Bank Holidays (with extra sessions between Xmas and New Year) for patients needing urgent dental treatment. This service is jointly commissioned by Enfield and Haringey PCTs and is currently provided by an Enfield GDP. All referrals to the service are via Camidoc.

Between May and December 2008 40 sessions were held; 154 patients were seen (an average of approximately 4 patients per session).

The Out of Hours three hour service on Sundays and Bank Holidays currently costs the NHS Haringey approximately £18.000 per year however Enfield and Haringey have renegotiated the cost of this service from July 2009. After that date the service will be provided for a total cost of £19,175 to be split between Enfield and Haringey on a 75/25% basis. Therefore this service will in future cost Haringey £4,793 for a full financial year.

7. STAKEHOLDER'S VIEWS

A list of the individual stakeholders and organisations that have taken part in this oral health needs assessment is given at the end of the document. Stakeholder's views were expressed through documents, emails, telephone discussion, interview and at a stakeholder meeting on March 2nd, involving both plenary and working group sessions.

7.1 ACCESS

The Patient Advice and Liaison Service (PALS) reported that there was much uncertainty about how to go about finding an NHS dentist both in-hours and out of hours and that patients reported problems of getting an urgent appointment.

Many stakeholders commented that they did not know where to go to get information about services, treatments, charges and location. Stakeholders emphasised the need for a 24 hour helpline. It was noted by stakeholders that some boroughs had introduced a mobile service to improve access.

There was a widely expressed view that many people did not understand NHS charges nor the system of exemptions. It was also felt that people on low incomes could not meet the costs of dental care. PALS reported that patient concern over charging was one of the most frequent reasons for calls concerning dentistry and that many patients felt they had insufficient information on charges or felt they had been coerced into private treatment.

Both PALS and the complaints department noted that patients would like more information on what they were entitled to. They proposed that the existing web site could be improved.

The complaints officer noted that most of the 20 formal complaints received each year concerning dentistry related to inadequate information being given to patients about the nature and cost of the procedure.

Some stakeholders expressed the view that lack of uptake in some areas might be the result of language problems and that there was a need for improved translation services.

It was noted that people tend to find dentists by personal recommendation and are happy to travel further to see their dentist than to see a GP.

Some stakeholders expressed concern about the suitability of dental premises with regard to accessibility for patients.

7.2 ORAL HEALTH IMPROVEMENT

At the stakeholder meeting there was some discussion about the use of the Index of Multiple Deprivation (IMD) as a measure of oral health need. Some stakeholders felt that the IMD did not adequately take into account the needs of black and ethnic minorities, asylum seekers and those of with different cultures.

Concern was expressed by some stakeholders that action did not appear to have been taken in those schools that were showing very high level of decay from childrens oral health surveys. There was also some discussion about using data only on decayed teeth to represent dental ill health. The consensus was that one measure was adequate

and that gum disease was given inadequate weight.

7.3 PREVENTION

There was widespread support at the stakeholder meeting for an approach that encouraged prevention rather than cure. Several dentists expressed the view that the current funding system did not encourage a preventive strategy. Stakeholders expressed the view that a skill mix in practices could ensure best use of resources to solve this problem. It was noted that the use of dental care professionals, such as extended duty dental nurses, dental hygienists and dental therapists could allow the dentist to do the more skilled work. Several stakeholders also noted that there are very few dental care professionals working in NHS practices.

It was noted that it was a challenge to commissioners to use newly available money to implement a preventative strategy rather than continuing to purchase more UDAs from GDPs.

There was concern that oral health programmes were being hampered due to a shortage of health promotion staff. Stakeholders were surprised that there had been cuts in the PCT Dental Service and these had had a direct effect on the work carried out in schools.

Concern was also expressed about a lack of preventive service at all for older people. People concluded that the focus needed to be on a new vision of prevention while acknowledging that this would need more resources.

The dental public health adviser to NHS London noted that commissioners wishing to pursue a preventative programme could develop the role of extended duty dental nurses to visit schools where there is persistent untreated decay to apply fluoride varnish to teeth. He noted that this is an evidence-based programme.

There was some discussion at the Stakeholder Meeting of the fact that there is only one oral health promoter in Haringey in contrast with Tower Hamlets where there are up to ten oral health promoters dealing with this particular care group.

It was noted that the majority of Oral Health Promotion Practitioners are currently employed by Primary Care Trust commissioned Dental Services but there that they have been allocated varying NHS staff band levels across the country. It was also noted that there are currently attempts to resolve this in such a way as to allow these professionals to work at a higher level than previously.

7.4 QUALITY OF SERVICES

Some dentists and the infection control nurse specialist expressed concern about the suitability of many Haringey dental premises with regard to meeting infection control standards.

Stakeholders expected that GDPs would ensure that their practices would meet the mandatory and other standards including those proposed by NICE. Some stakeholders proposed that further quality measures should be considered, such as a Dental Quality Outcome Framework similar to the system that exists for GPs.

7.5 SPECIALIST SERVICES

One dentist expressed that there is a perception among GDPs that they are less supported by secondary services than ever.

Many dentists expressed concern about patient pathways for endodontic and periodontic treatment. It was noted that referrals to hospitals were increasingly returned. This was perceived to be due to hospitals not wanting to be seen to fail to meet waiting time targets.

Stakeholders recognised the importance of developing specialist roles within primary care that would include the appointment of dentists with a special interest in endodontics, periodontics and minor surgery to reduce waiting times and cost to the PCT.

Some stakeholders expressed concern about the possible impact that some of expanding primary and community based specialist care on secondary care providers ie. The reduction in referrals.

Stakeholders expressed the view that orthodontic services are good in Haringey and there is a good service from dental hospitals to help with treatment plans.

Stakeholders expressed the view that there is a need for a clinical pathway that would help define the relationship between GDP, primary care sedation service and hospital service. Specifically a view was expressed that sedation services should be improved for patients with learning difficulty. The dental public health adviser to NHS London noted that there is a need to monitor sedation practices closely to ensure quality, adherence to clinical guidelines and the targeting of such services to where they are really needed.

The PALS department reported that patients had expressed concern where they had been referred to hospital where they were assessed, only to find that they were then referred back to their own dentist for 'treatment' or no treatment. Frequently it was not made clear to patients that the referral was for assessment and not necessarily for treatment.

Patient expectation was noted to be an issue in cases where GDPs referred patients to hospital for a consultant opinion about a treatment plan but patients were then expecting treatment.

Several stakeholders expressed concern at the availability of domiciliary services. It was noted that the PCTDS were only able to treat highly complex cases, although they were often asked to make assessments by health professionals who did not know of any other referral route (e.g staff in residential homes).

7.6 SPECIFIC PATIENT GROUPS

Elderly Patients

Concerns were expressed about dental care for older people by a variety of stakeholders. Specific issues were access, cost and the need to establish preventive programmes. Age Concern identified several areas of need: those who may not have accessible NHS dentistry; those in residential settings; and those in need of domiciliary care. They also noted that cost, or fear of the cost, of paying for dental treatment can be an issue in accessing services and that although older people on low incomes are entitled to free treatment or help with costs, the system to claim this benefit is complex. The need to improve oral services for older people was strongly supported by the Older People's Forum.

Children

A variety of stakeholders including dentists and oral health promotors expressed concern about a lack of specific provision in Haringey for children under the age of five with high treatment need. Several dentists noted that the sedation practice could not treat children

below the age of six.

It was noted that as part of the Sure Start programme there had been a scheme involving ten GDPs that offered a targeted service for very young children.

Vulnerable Groups

Concern was raised that whilst access for the general adult population was acceptable, there was not enough focus on vulnerable adults and vulnerable children. Stakeholders raised the issue of dental care for those who were travellers, others who were in Haringey for only short periods before moving on, as well as asylum seekers. There was also a need for a targeted service for substance users and a need to assess children on the at-risk-register. Stake holders felt that there was insufficient information about the oral health of many vulnerable groups and that steps should be taken to remedy this omission.

Several stakeholders expressed concern about the adequacy of dental services for people in residential care homes. It was suggested that there should be an audit to check whether homes were complying with the requirement to have a care plan for each resident which included care of their mouth, gums, teeth or dentures, and the requirement that residents should see a dentist on an annual basis.

Several of the stakeholders who had been working with those with special needs made specific proposals that would improve the service. This included carrying out an audit on learning disabilities and oral health needs, reviewing the management of adults with learning difficulties in acute settings including waiting lists, developing a locally enhanced service contract for dentists that might involve an annual dental visit to residential homes, training for GDPs and their practice teams, a need to familiarise GPs and GDPs concerning oral medication for various conditions eg epilepsy, increasing the use of 'social story', improving commissioning for both primary and secondary care.

7.7 ENGAGEMENT WITH LOCAL PEOPLE

Some stakeholders expressed the view that more local people should be involved in the development of a strategy and action plan and that this involvement should continue into the commissioning of services and the implementation and subsequent monitoring of new services.

7.8 THE PCT

A view was expressed that the PCT should review its own Commissioning Directorate's progress in adopting the levers and processes recommended by the Department of Health. It was also felt that within the PCT there should be board-level oversight and leadership with regard to dentistry.

The view was expressed that the time allocation of the Dental Advisor was insufficient to carry out all of the designated roles.

The dental public health adviser to NHS London noted that there is often a lack of integration between dental services and other primary care services which can be seen in polyclinic planning. He also noted that there is often little support within PCTS for the dental commissioning manager.

The secretary of the LDC expressed the view that while there is a good relationship with the PCT, dentistry does not appear to be a high priority issue.

8. DISCUSSION AND RECOMMENDATIONS

8.1 ACCESS

Haringey has a high number of practices providing NHS services and compares favourably to other areas of London and the country in terms of uptake of services.

Nevertheless the number of patients seeing a dentist has fallen since 2006 and there is some evidence to suggest that the public is not aware of the services available and that there is confusion about the nature and cost of treatment.

The level of uptake of services varies throughout the borough with some areas of high deprivation showing a relatively low level of demand.

Haringey has a well established Orthodontic practice and a developing Sedation practice. However there is no referral management for the sedation practice and it is not clear that only appropriate cases are being referred. There is a long wait for some types of dental treatment in a hospital. In some cases hospital referrals are refused leaving the dentist unsure of where to refer the patient.

The particular needs of some vulnerable groups such as the housebound, those in care homes and drug users, do not appear to be fully catered for by dental services at present.

Recommendations:

The PCT should ensure that all patients are able to access NHS dental services. This should involve the following:

1. **Developing evidence-based clinical pathways between primary care, specialist services and secondary care**
2. **Taking steps to encourage the uptake of services in areas of high need and low uptake, particularly Northumberland Park**
3. **Reviewing the PCTDS and agreeing a Service Level Agreement**
4. **Considering the need for an intermediate special service in endodontics and periodontics**
5. **Reviewing the translation services available to GDPs**
6. **Carrying out a review of the oral health needs of those in residential care homes**
7. **Reviewing the current domiciliary provision and considering the need for the introduction of a transport service**
8. **Developing a communication strategy to publicise the dental access helpline as recommended by the Steele Review**
9. **Assessing the cost of supporting all dental practices to become fully computerised as recommended by the Steele Review**

10. Continuing to monitoring dental contracts to ensure equality of access to services

8.2 PREVENTATIVE DENTISTRY AND ORAL HEALTH IMPROVEMENT

Although the general picture of oral health in Haringey is good, there is a wide variation across the borough, with very high levels of dental disease in certain areas. Despite this screening activities and some oral health promotion programmes have been reduced in the past few years.

As the Steele Review acknowledges, the new system does not reward health promotionactivities at present. Moreover in Haringey there is a traditional skill mix with very few hygienists and no therapists nor any experimentation with extended duty dental nurses. Such professionals could be used in health promotion activities.

Recommendations

The PCT should develop an oral health promotionstrategy and action plan which should include

1. **Preventative programmes for specific groups, including pre-school children, programmes in schools and programmes for older people**

2. **Steps to develop the skill mix of the workforce in dental practices so as to maximise resources to allow for preventative dentistry and health improvement.**

8.3 QUALITY

The Steele Review recognises the need for a quality framework to be developed for dentistry at a national level. There are concerns with regard to the suitability of many of the dental premises in Haringey. There is also concern about standards of infection control.

Recommendations:

1. **The PCT should be aware of the need to encourage and reward excellent quality in dental services**

2. **The PCT should continue to monitor and support practices to ensuring that they meet all relevant quality standards**

3. **The PCT should continue to support dental practices to ensure that essential quality requirements are met in infection control and to ensure that all practices are moving towards best practice in decontamination**

8.4 THE PCT

Since 2006 the PCT has had a significant task in taking on its new role in relation to the new contract. The workforce involved with dental commissioning has had to expand since that time but there is an enduring perception that dentistry is peripheral to the main business of the PCT.

The Dental Adviser to the PCT is shared with 3 other PCTs as well as running a busy dental practice. The role has changed significantly since the 2006 reforms and the availability of increasingly detailed information on each practice and the need to commission appropriate services for the local population means that clinical advice and expertise is increasingly important. In this context there appears to be a need to review the capacity of the dental adviser.

Similarly there is no specialist in dental public health in the public health department of the PCT. While some London PCTs employ a consultant in dental public health, the clinical director of the PCTDS provides specialist dental public health advice to Haringey and Enfield PCTs on an informal basis.

In the course of preparing this document, there has been engagement on oral health issues with a wider range of people both inside and outside the PCT than at any previous stage. The PCT should maintain and build on this engagement.

Recommendations:

1. **The PCT should review responsibility for dentistry on decision-making bodies at all levels of the PCT as recommended in the Steele Review**

2. **The PCT should review Dental Adviser and Dental Public Health capacity to ensure that there is the appropriate support and expertise to allow for World Class Commissioning of Dentistry in Haringey as recommended in the Steele Review**

3. **The PCT should build on the contacts made in preparing this report to ensure appropriate engagement and involvement**

9. LIST OF STAKEHOLDERS INVOLVED

Nilesh Amin	General Dental Practitioner and Vocational Trainer
Derek Armstrong	Estates Manager
Nancy Augustt	Patient Advice and Liaison Service, NHS Haringey
Mayur Bhatt	Dental Adviser, NHS Haringey
Martin Booyens	Sedation Specialist
Angie Buxacott	Haringey LINK
Councillor Gideon Bull	Overview and Scrutiny Committee, Haringey Council
Moe Carey	Haringey Forum for Older People
Colin Chapman	Manager, Drug Advisory Service NHS Haringey
Dorian Cole	Manager, Quit Smoking Team NHS Haringey
Hazel Collins	General Dental Practitioner
Mr Daramola	General Dental Practitioner
Melanie Danan	The Interlink Foundation
Alison Duggal	Public Health, NHS Haringey
Robert Edmonds	Age Concern
Stephen Farrow	Public Health Consultant, Public Health Direct
John Fenton	Vocational Trainer and General Dental Practitioner
Mark Fordham	Dental Finance Manager, NHS Haringey
Keith Gardner	Complaints Manager, NHS Haringey
David Gibbons	Public Health Consultant, Public Health Direct
Catherine Gizzi	PCT Dental Service
Charlotte Jeavons	Oral Health Promoter, NHS Enfield
Amol Joshi	Dental Contracts Manager, NHS Haringey
Nick Kendall	Dental Public Health Adviser, London
Kris Khambhaita	Infection Control Adviser, NHS Haringey
Maggie Kubiangha	Oral Health Promotion, NHS Haringey
Lorraine Langley	Assitant Manager, Health Learning DisabilityTeam
Roger Levy	Local Dental Committee
Sandra Lynch	Practice Manager, Orthodontic Practice
David Lyons	Dental Lead, NHS Haringey
Rob Mack	Haringey Council
Douglas Maitland-Jones	Care Hones, Mental Health
Mahendra Makan	Local Dental Committee
Sona Matani	Chief Exec, Selby Trust
Nemish Mehta	Practice Manager
Gwen Moulster	Nurse Consultant, Learning Disabilities
Pat Murphy	General Dental Practitioner
Rosalind Murphy	Care Homes for Older People
Larry O'Mahoney	Manager Irish Day Centre
Suran Pereira	Consultant Oral Surgeon, Chase Farm
HA Patel	Orthodontist
Ketan Patel	General Dental Practitioner and Out-of-hours service provider

Parimal Patel	General Dental Practitioner and Vocational Trainer and
Trevor Payne	Local Dental Committee
Tina Raphael	Dental Commissioning Manager, NHS Haringey
Roy Ridler	Estates, NHS Haringey
Steve Simmons	PCT Dental Service
Manuela Toporowska	Age Concern