Oral Health Needs Assessment
Wakefield District

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1.0 Executive summary
Over the last thirty years there have been significant improvements in oral health in the UK, however many people still suffer the pain and discomfort of oral diseases which are largely preventable and remain a major public health problem.

Decaying teeth constitutes the number one, most prevalent disease globally, with tooth decay (dental caries) and gum disease (periodontal disease) being the most common dental problems in the UK. There is a cumulative effect if unchecked in early stages of life, which leads to more pervasive decay in adulthood and higher chances of extensive tooth loss in later life.

The distribution and severity of oral diseases varies between and within countries and regions and whilst sections of the British population enjoy very good levels of oral health, stark inequalities exist with some of the poorest and most disadvantaged sections of society facing significant oral health problems.

This oral health needs assessment (OHNA) provides a detailed picture of the oral health needs of the Wakefield district and the commissioned dental services and oral health promotion services to meet those needs. It identifies gaps in provision and identifies key issues to be prioritised and addressed within future work on oral health in the district.

Oral health of children
5 year olds in Wakefield are now 1½ times more likely to have some dental decay than 5 year olds across England. For an average group of 100 Wakefield children aged 5, there would be 41 with some dental decay, compared with 28 from an average group of 100 children from England. In an average group of 100 children from Yorkshire and Humber, 34 would have some dental decay. There is also some evidence that the oral health of 5 year olds in Wakefield compared to the rest of England may have got worse over the last 5 years. According to the Public Health Outcomes Framework, amongst the 50 local authorities across the North of England PHE region, Wakefield district ranks 41st for mean decayed teeth in 5 year olds.

For an average group of 100 Wakefield 12 year old children, there would be 40 with some decayed teeth compared to an average group of 100 England 12 year old children of which 33 would have some decayed teeth.

In a 2013 survey one in five Wakefield 3 year olds had any decayed teeth. This was the highest rate across all Yorkshire and Humber local authorities. For an average group of 100 Wakefield 3 year old children, 20 would have some decayed teeth compared to an average group of England 3 year olds, of which 12 would have some decayed teeth.

There is a socio-economic gradient to oral health in the region, with children in more deprived areas having worse oral health than children in more affluent areas.

The 2011-12 epidemiological survey of 5 year olds and the 2013 survey of 3 year olds in Wakefield did not use a large sample size in comparison with other areas. It is therefore recommended that future epidemiological surveys in Wakefield ensure a large sample size, in order to produce results that can be more certainly evaluated.
Oral Health of Adults
Please see PHE West Yorkshire Regional OHNA (Chapter 5). Summary findings –

- The oral health of adults has improved significantly over the last 40 years with more of the population retaining their natural teeth throughout their lifetime.
- In Yorkshire and Humber, 30% of adults had tooth decay and 2% had severe gum disease.
- Men from materially deplete backgrounds were more likely to experience higher levels of tooth decay and gum disease but least likely to visit a dentist.
- People in Wakefield were more likely to report a perceived need for treatment than other areas.
- People in Yorkshire and Humber were more likely to wear a denture than nationally.

Tooth Brushing
There is a significant proportion of children in Wakefield who do not brush their teeth to the recommended standard. This has a significant influence on high rates of decay. Only 80% of 10 year olds and 73% of parents of 1-6 year olds stated their child brushed their teeth at least twice a day. Of the 73% of parents that stated their child brushed their teeth enough, only 85% actually brushed to the recommended standard. 1 in 4 parents report not starting to brush their child’s teeth until after their first birthday (the recommended standard is when the first teeth come through). 1 in 5 children aged 1-6 have no parental involvement in tooth brushing.

Food and Diet
Between a quarter and a third of Wakefield school children report consuming fizzy drinks every day. Over a quarter of Wakefield children report eating confectionary every day. Just over a half of Wakefield young people in further education report drinking sugary fizzy drinks daily.

With more than half the adult and child population in Wakefield meeting none of the nutritional guidelines for fat, saturated fat, fibre, fruit, vegetables and protein, there is a high risk for tooth decay, oral cancer and other chronic diseases, negatively impacting oral health. Food poverty is an increasing issue in the borough and likely to worsen people’s diet and nutritional intake, which in turn will negatively impact oral health.

1 in 5 children aged 1 or over were reported to be going to bed with a bottle or free-flow cup. A third of parents of children 3 yrs old or more stated they still used a bottle or free-flow cup regularly. This is not in line with national guidance.

Tobacco and Alcohol
When both tobacco and alcohol products are used together, the risks of oral cancers are multiplied rather than added. The difference in risk can be as much as 35 times for groups with high alcohol and tobacco use. Wakefield is worse than the regional and national average across many of the indicators of harm from alcohol and with higher than average prevalence of smoking. There is therefore an increased risk of oral cancers in the Wakefield population, compared with other areas.
**Water Fluoridation**

Wakefield is not a water fluoridated area (naturally or man-made). Given the recent PHE report that provides evidence to support the claim that water fluoridation is safe and effective, the quality of the evidence has improved since Wakefield OSC reviewed this issue in 2007. It is recommended that Wakefield Council Overview and Scrutiny Committee reconsider a local water fluoridation scheme in order to improve the oral health of the children in the district. It is likely that it would close the inequality gap of oral health between the richest and poorest children across Wakefield.

**Dental Care**

Approximately 4 out of 5 adults in Wakefield report that they are registered with a dentist and 7 out of 10 have had a routine check-up in the last year. 1 in 6 adults report they needed emergency treatment at the dentist in the last year. A higher percentage of Wakefield adults access dental care than other West Yorkshire areas and England averages. 9% of parents of pre-school children report that it is difficult to get a routine appointment at a dentist and 6% state it is difficult to get an urgent appointment. Only 1 in 5 parents reported receiving ‘advice on looking after teeth’ from the dentist. 88% of parents stated that they were likely to follow advice given by a dentist. There are opportunities for dentists to give prevention messages to parents of pre-school children that they might respond to. This may be promoted through the new dental contract being piloted currently, but should also be explored locally with the Local Dental Committee and other key stakeholders.

Compared with some other West Yorkshire areas, dentists in Wakefield record less courses of fluoride varnish treatment. Given the high rates of dental caries in Wakefield amongst children, higher rates of fluoride varnish applications by dentists could make a significant contribution to improving oral health in the district.

In the local surveys (n=535) there was a high regard for dentists; with three-quarters of respondents stating they were likely to follow advice from a dentist.

**Emergency Oral Care**

There were over three thousand presentations for oral conditions at A+E between 2010 and 2014. While female presentations have remained stable, male presentations have increased significantly over the last three years. The age bands with the highest attendance were 16-25 and 26-35 (both 1 in 4 attendances). Just over 1 in every 6 attendances were children between 0 and 15 years old. The most common presentation recorded was ‘Dental abscess/infection’ (45%). The most common discharge route (1 in 3) was referral to a dentist.

The rate of dental calls to NHS 111 service across Wakefield increased in 2013 in areas of higher deprivation. This was a fairly strong relationship.

**Orthodontics**

It is estimated that of all the 12 year old children in Wakefield who need a brace and would be prepared to wear one, only half are currently benefitting from an orthodontic appliance.
Even though this represents an unsatisfactory treatment rate of 50%, it is better than England (41.2%) and Yorkshire (30.4%) estimated treatment rates.

**Wakefield Oral Health Promotion Service**
This local service is delivered by the Community Dental Service (Mid-Yorks NHS Trust). It provides 4,500 oral health packs to all 6 month old children (Brushing for Smiles), provides tooth brushing programmes in nurseries in deprived areas (Just Brush), applies fluoride varnish to over 1000 pre-school children (Work together—Smile forever) and delivers health promotion sessions to school children, carers of people with learning disabilities and PEG feeds, care home staff and student health visitors. Other adult vulnerable groups in Wakefield may benefit from this oral health promotion service.

**Dental Anxiety and Phobia**
In Wakefield district between 10,000 and 33,000 people may experience high dental anxiety and between 10,000 and 16,000 people may meet the diagnostic criteria for dental phobia. The Wakefield Community Dental Service sees phobic patients currently in community clinics but is not able to provide intravenous sedation or formal psychological support. Other localities have access to cognitive behavioural treatment as part of a designated pathway for anxious/phobic patients. Evidence suggests that behavioural interventions have a positive effect on dental fear, and should, therefore, be incorporated in any treatment of highly fearful patients. Clinical pathways and services for people with dental phobia and high dental anxiety should be reviewed locally in order to address this treatment gap.

There is a dental phobia support group in Wakefield called ‘Gentle Steps’ which is a valuable but fragile community asset. With continued support from statutory agencies, it can continue to make a significant difference to a potentially large group of people with dental phobia in Wakefield.

**Surveys of Vulnerable Groups in Wakefield**
During 2014 four surveys were conducted for this needs assessment among parents of pre-school children (n=299), older people (n=74), people using MH services (n=104) and care home managers (n=33).

Results for pre-school children –
- 1 in 5 children aged 1-6 years old do not have parental involvement in brushing
- 1 in 4 children aged 1-6 years old do not brush their teeth twice a day
- 1 in 5 children drank fruit juice as one of the most frequently consumed drinks
- Nearly 1 in 3 drank squash as one of the most frequently consumed drinks
- 7 out of 10 parents stated that ‘age related’ was the most important factor in choosing toothpaste. Only a third considered fluoride content.
- 9 out of 10 parents stated they were likely to follow advice given by a dentist.

Results for older people –
- Two-thirds of older people brushed their teeth at least twice a day
• 1 in 10 older people had problems accessing routine dental care
• 7 out of 10 older people were likely to follow advice from a dentist

Results from mental health service users (mainly older people) –
• Half the people using MH services brushed their teeth at least twice a day
• Half the people using mental health services were likely to follow advice from a dentist

Results from care home managers –
• Over a third of homes had had no oral health training for staff
• 4 out of 5 homes stated their residents accessed routine dental care
• Problems were reported in accessing urgent care; that transport was not available and dentists would not visit the home.
• Less than a third stated they undertook an oral health assessment on admission
• Nearly two-thirds stated tooth brushing occurred twice a day, but less than a third reported this was routinely documented.
### 1.1 Key Recommendations

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<td>All Stakeholders</td>
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<td>2. The rates of tooth brushing twice a day in children need to be increased across the district.</td>
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<td>3. Health promotion activities need to be strengthened to address the high number of children who drink sugary drinks and eat confectionary every day.</td>
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<td>Local Dental Committee, NHS England</td>
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<td>NHS England</td>
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<td>7. On-going health promotion efforts in tackling alcohol and tobacco harm in the district should include the risks of oral cancer.</td>
<td>Wakefield Council, PHE</td>
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<td>Wakefield Council, LDC</td>
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<td>Wakefield Council</td>
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<td>10. Clinical pathways and services for people with dental phobia and high dental anxiety should be reviewed locally in order to address the treatment gaps.</td>
<td>NHS England</td>
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<td>11. The scope of the oral health promotion service could be widened to include other adult vulnerable groups.</td>
<td>Wakefield Council</td>
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<td>12. Future epidemiological surveys in Wakefield should ensure a large sample size, in order to produce results that can be analysed with more certainty.</td>
<td>Community Dental Service, Wakefield Council</td>
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<td>13. The information within this OHNA should inform the service design and procurement of the Wakefield Oral Health Promotion service during 2015/16.</td>
<td>Wakefield Council</td>
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2.0 Introduction

2.1 Context for oral health improvement
Over the last thirty years there have been significant improvements in oral health in the UK however many people still suffer the pain and discomfort of oral diseases which are largely preventable and remain a major public health problem.

The World Health Organisation defines oral health in broad terms. “It means more than good teeth: it is integral to general health and is essential for wellbeing….allows us to speak, smile, kiss, touch, smell, taste, chew, swallow and to cry out in pain’. Poor oral health “restricts activities in school, at work and at home causing millions of school and work hours to be lost each year the world over. Moreover, the psychosocial impact of these diseases often significantly diminishes quality of life” (World Health Organisation, 2003).

Decaying teeth (dental caries) constitutes the number one, most prevalent disease globally, with an estimated 2.4 billion people (35.3% of the global population) experiencing dental caries of permanent teeth in the Global Burden of Disease study 2010 (Vos et al, 2012). Given the impact this can have as described in the WHO definition of oral health (above) this has a great impact on quality of life for many people in our world.

Tooth decay (dental caries) and gum disease (periodontal disease) are the most common dental problems in the UK. They can be painful, expensive to treat and can seriously damage health if left unchecked (Department of Health 2011). However, both problems are largely preventable (Levine and Stillman-Lowe 2009).

Oral health is an integral part of general health; many of the key risk factors that lead to poor oral health are risk factors for other diseases. A common risk factor approach to health promotion recognises that chronic non communicable diseases and conditions such as obesity, stroke, heart disease, cancer, diabetes and oral diseases share a set of common risk factors and by concentrating on a small number of risk factors which may impact on a number of diseases will result in greater efficiency than a disease specific approach.

The distribution and severity of oral diseases varies between and within countries and regions and whilst sections of society enjoy very good levels of oral health, stark inequalities exist with some of the most vulnerable, disadvantaged and socially excluded facing significant oral health problems. It is important therefore that we not only aim to improve the oral health of the population but seek to address these inequalities.

This oral health needs assessment (OHNA) provides a detailed picture of the oral health needs of the Wakefield district and the commissioned dental services and oral health promotion services to meet those needs. It identifies gaps in provision and identifies key issues to be prioritised and addressed within future work on oral health in the district.

2.2 National context
The overall oral health of the UK has improved significantly over the last 40 years. The percentage of adults who do not have any natural teeth (edentate) has reduced from 37% in 1968 and 28% in 1978, to 6% in 2009 (HSCIC, 2011). Rates of decayed teeth in children
have also reduced over the last 40 years with children aged 5, 12 and 15 having greatly reduced average numbers of decayed teeth as the graph below indicates –

**Figure 1 - Oral Health in England 1973 - 2003**

Since 2006 Primary Care Trusts (PCTs) were given specific responsibilities for dental public health. A number of key documents were produced by the Department of Health to support PCTs in the delivery of evidence based oral health improvement and the delivery of high quality accessible and appropriate dental services

- Delivering Better Oral Health: An evidence based tool kit for prevention (Department of Health and British Association for the Study of Community Dentistry, 2009).

Recently the NHS White Paper, Equity and Excellence: Liberating the NHS (Department of Health, 2010b) again restated the important focus on improving the oral health of school children. It proposed the introduction of a new dental contract, one that is focused on improving quality through capitation payments and registration. This contract is currently being piloted with approximately 70 national pilots (one within Wakefield district). The commitment to improve the oral health of children is further emphasised in the Public Health
Outcomes Framework where an oral health indicator regarding the dental health of 5 year old children is included.

Since April 2013, NHS England (previously the NHS Commissioning Board) has been working with local authorities and Public Health England to develop and deliver oral health improvement strategies and commissioning plans specific to the needs of local populations (NHS Commissioning Board, 2012). Oral health needs assessments are required to inform joint strategic needs assessments. Local authorities have the responsibility for commissioning surveys of dental health, dental screening and improving the oral health of their populations.

2.3 Local context

Wakefield has considered oral health as a priority for a number of years. In the early 2000’s Wakefield Health Authority produced an oral health strategy which was subsequently superseded by Wakefield PCT’s oral health strategy in 2008. A working group developed this strategy which included a dental public health consultant (Wakefield and Kirklees - joint post) and a local dental practice advisor for the PCT. Some of the recommended 69 actions within the strategy were taken up by the Wakefield Oral Health promotion service. The actions were reviewed locally and it was identified that only those within the oral health promotion team performance indicators were monitored. Many actions were not measurable and did not have target levels assigned and so were unable to be effectively monitored.

In 2007 Wakefield Social Care and Health Overview and Scrutiny Committee at the Council conducted a review of children’s oral health in the district (Wakefield SCHOSC, 2007). The recommendations included consideration of water fluoridation, public health education messages on oral health, continuation of epidemiological surveys, disseminating findings and using contractual opportunities to promote prevention in dental services. The production of the 2008 Oral Health strategy was also prompted by one of the recommendations in the scrutiny review in 2007.

Oral health in children is one of the key indicators in the new Public Health Outcomes Framework and therefore continues to be a priority for the public health team at Wakefield Council. The Council also commissions the oral health promotion service and is due to re-tender this service in 2014/15. As such, a review of oral health in Wakefield district was necessary to identify needs within the population that would benefit from this service in the new contract period. The findings of this OHNA will help to shape the new service specification for the oral health promotion service.

Following the reforms to the NHS on 1st April 2013, the new alignment of responsibilities in oral health to new organisations has meant a significant re-shaping of the landscape locally. Undertaking an OHNA has been a helpful way to pull together stakeholders from the new organisations into a working group which would take forward oral health concerns in Wakefield.
3.0 Oral Health Needs Assessment

3.1 What is a OHNA
An oral health needs assessment is a tool for identifying the oral health needs and oral healthcare needs of a population to target resources towards improving the oral health of those at specific risk or in underserved population subgroups. The process involves establishing and describing the oral health of a population, ascertaining their needs, measuring the capacity of existing services to meet these needs and where gaps exist, identifying new or alternative ways in which such gaps can be prioritised and filled.

3.2 Reason for an OHNA
The restructuring of the NHS in April 2013 followed the passing of the Health and Social Care Act 2012. The Act conferred the responsibility for the commissioning of NHS dental services to NHS England and conferred the responsibility for health improvement, including oral health improvement to local authorities.

Local authorities now have a statutory requirement to assess their local population’s oral health needs. An oral health needs assessment can help local authorities identify the oral health needs in their local communities for inclusion in the joint strategic needs assessment.

3.3 Local Arrangements for the OHNA
This Wakefield oral health needs assessment has benefitted greatly from input from various local stakeholders who have assisted the authors in writing this document and identifying recommendations to take forward. A Wakefield Oral Health Advisory Group was formed to oversee the development of this needs assessment. This group has committed to continue meeting after completion of this report, to monitor and co-ordinate the recommendations from this needs assessment.

Membership of the group has been as follows –

- Public Health Manager (Wakefield District Council)
- Public Health Specialty Registrar (Wakefield District Council)
- Members of the Wakefield Local Dental Committee
- Clinical Manager (Wakefield Salaried Dental Service)
- Oral Health Promotion Lead (Wakefield Salaried Dental Service)
- Consultant in Dental Public Health (Public Health England)
- Senior Dental Public Health Manager (Public Health England)
- Patient Representative (Independent Member and HealthWatch Rep)
- Consultant leads from dental specialties (Mid-Yorks NHS Trust - ad hoc basis)
- Commissioning Manager (NHS England – ad hoc basis)
4.0 Population and demographics

Wakefield District covers some 350 square kilometres and forms one of five districts which make up West Yorkshire. The main centres of population are Wakefield city; the five towns of the north east (Pontefract, Castleford, Knottingley, Normanton and Featherstone); Ossett and Horbury in the west and Hemsworth, South Elmsall and South Kirkby in the south-east. There are also scattered villages in the open countryside. The current size of the population in Wakefield is 327,627 people, making the district the 20th largest local authority area in England and Wales.

As is typical nationally, the Wakefield age profile shows the effect of baby-boom years of the 1950s and 1960s and greater numbers of older women than men. Overall numbers are projected to keep on increasing, albeit more slowly than elsewhere in the region, with improved life expectancy resulting in a greater proportion of the population being made up of older people.

Figure 2 – Wakefield Population Age Profile 1981 and 2012

When compared with many other metropolitan districts, Wakefield’s age profile has a smaller than average proportion of people in the 18-24 age-band (8%). This reflects the absence of any sizeable university presence within the district. In Leeds, a large university city, around 13% of people are aged 18-24, for example.

4.1 Population Changes (Births, Deaths and Migration)

The population is projected to grow to 350,459 people by 2021. Compared to now, the number of people aged under 16 is projected to increase by 10% (around 6,000 more people), the working age population (16-64) is projected to rise by 2% (around 4,100 more
people); and the population aged 65 and over is projected to rise by 25% (around 14,000 more people).

Between 2011 and 2012 there were 978 more births than deaths; 260 more people left the district to live elsewhere in England and Wales than moved in; and 492 more people migrated in from overseas than left for overseas destinations.

Between 1991 and 2001 the number of deaths per year remained fairly constant, but there was a steady decline in births. Population growth would have ceased had it not been for an increase in net migration (Figure 2). Since 2001 the number of births has been increasing again. Economic migration from Eastern Europe kept up net migration between 2003 and 2007 but in the last few years the number of people arriving in the district (from within the UK and from overseas) has been close to the number of people leaving.

Figure 3 – Wakefield – Births, Deaths and Migration (1991 – 2011)

Immigration from new EU states has also contributed to the increase in the district’s fertility rate. Between 2007 and 2012 there were 1,015 live births in Wakefield to mothers from the new EU states and in 2012 13.3% of all births were to mothers born outside of the UK compared to 6.9% in 2004.

4.2 Lifestyle profiles
Local health data shows that less than one third of all adults aged over 20 in Wakefield District have a normal Body Mass Index (BMI). Problems with being overweight or obese are more common among people in middle age and there is a strong correlation between obesity and deprivation.
National survey results show that smoking prevalence has been in gradual decline over the last 15 years although the reductions have slowed in the last few years. Survey data shows that 23% of adults in Wakefield smoke, compared to 20% across England as a whole. Smoking is even more common among people in routine and manual occupations, 34% of whom smoke compared to 30% across England.

In 2010/11, hospital admissions in the district attributable to smoking were 4,014 of 75,056 (5.3%), costing NHS Wakefield approximately £7.2m or £19 per head of population. The latest reports show that 615 adults died in 2010 from diseases that can be caused by smoking.

Excessive and unsafe use of alcohol is also a problem within the district. Approximately 14.5% of the adult population across the district are estimated to be drinking at hazardous or harmful levels and men are more than twice as likely as women to drink excessively. Local analysis has also shown that unemployed people are significantly more likely to be drinking at higher levels than people who work.

Estimates of the proportion (%) of adults who consume at least twice the daily recommended amount of alcohol in a single drinking session, suggest that Wakefield is significantly worse (26.1% of adults) than the national average. Under-18s admissions to hospital due to alcohol specific conditions (2008/09-2010/11) – 87.0 admissions per 100,000 under 18’s – are significantly higher than the national rate of 55.8.

Wakefield has a relatively low level of participation in sport and active recreation in the sub-region, and the activity levels have changed very little in recent years. Just 22.6% of people aged 16 and over participate in sport and active recreation, at moderate intensity, at a level equivalent to 30 minutes on 3 or more days a week. This is much lower than the England (26.0%) and Yorkshire (27.0%) average and lower than most other West Yorkshire districts.
4.3 Deprivation and ill health

4.3.1 Deprivation
As is the case across the country, there are parts of the Wakefield district where more people tend to be poorer, or less healthy, or more likely to be out of work. The Index of Multiple Deprivation (IMD) is calculated for every neighbourhood in England every three years, and it combines issues such as income, employment, education, crime and housing.

The IMD 2010 shows that conditions have improved for some of the district’s most deprived areas relative to deprivation elsewhere in England. At the district level Wakefield is now the 67th most deprived district in England (out of 326 districts). The IMD 2010 also shows that 40,459 people in the district are living in neighbourhoods amongst the top 10% most deprived in England. This is 12.5% of the district’s population, down from 14.6% of the population in 2007. The geography of multiple deprivation is shown in Figure 3.
4.3.2 Poverty
Across the district there are almost 13,500 children aged under-16 (22.5% of this age group) living in households where at least one parent or guardian is claiming out-of-work benefits. Although this is around 200 fewer children than in 2010, it remains higher than the national rate of 20.2%. Furthermore, there are wide variations within the district. At the individual neighbourhood level there are some parts of the district where the rate is over 50%.

The latest data on the extent of fuel poverty (2011) show that 9.4% of households in the district have required fuel costs that are above average which, if spent, would leave the household with an income below the official poverty line. Across England as a whole the rate is slightly higher, at 10.9%.

4.3.3 Health Inequalities
Over recent years there have been gradual improvements to the life expectancy in the Wakefield district. Based on latest calculations (2009-11), males are dying on average at the age of 77.5, compared to around 78.9 years of age across England as a whole. As is the pattern nationally, females are, on average, living longer than males, to about the age of 81.5. This compares to a national life expectancy amongst women of 82.9.
Significant differences remain within the district. Males in the most deprived parts of the district (top 10%) are living, on average, 10.6 years less than their more affluent counterparts (10% least deprived). For females the gap is 8.9 years. There is also evidence to suggest that this gap is widening.

Wakefield loses a disproportionately large amount of its life-years in the most deprived communities to chronic heart disease (CHD), lung cancer, chronic obstructive pulmonary disease (COPD) and – particularly in men – chronic liver disease.

5.0 Causes and impacts of poor oral disease

5.1 Social determinants of oral diseases
The World Health Organisation defines the social determinants of health as the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities, which are the unfair and avoidable differences in health status seen within and between countries.

The relationship between oral diseases and the social determinants of health are inextricably bound together. It is well-recognised that oral health is influenced by a wide range of determinants starting from individual lifestyle choices such as sugar intake, to national policy, for example smoke-free environments and policies tackling sugar and alcohol availability. It is essential that for a successful public health approach, these wider determinants must be focussed upon through a partnership approach.

5.2 Oral Health Challenges and Impacts
Gum disease and dental decay are preventable and share some aetiological factors such as poor oral hygiene, diet and smoking. Various behavioural practices (outlined below) can affect oral and general health.

5.2.1 Food and Nutrition
Dental decay occurs when a tooth undergoes the process of demineralisation in response to the acids produced as a result of interaction between dietary sugars and plaque bacteria. The sugars causing decay are derived mainly from processed and manufactured foods such as confectionary, biscuits and soft drinks. The majority of the people of England consume more than the recommended 60gms of sugar per day. Government advice suggests limiting
the frequency and amount of sugars consumed, particularly restricted to mealtimes (Department of Health, 2009).

Wakefield district is famous for its food heritage – boasting the Rhubarb Triangle and Liquorice Festival. Many large food businesses (such as Coca-Cola, Asda and Haribo) have chosen to invest in the district. However, despite the food history and food production, what people living and working in Wakefield choose to eat is far from healthy (Draft Wakefield Food Plan, 2014).

Wakefield District Public Health team have been using the Health Related Behaviour Survey every two years since 2009 as a way of collecting robust information about children’s and young people’s health and lifestyles. This latest survey reached a large sample size of Year 5 children (n=950) and Year 9 children (n=2,200) and was undertaken in the spring term of 2013.

In response to the question “How often do you drink fizzy drinks?” children responded with the following answers –

**Figure 6 - Frequency of fizzy drinks consumed by school year group**

There appears to be more frequent consumption of fizzy drinks in older children than younger children. Over 50% of year 5 students only drank fizzy drinks rarely or once a week compared with 40% of year 9 students. The percentage reporting more frequent consumption of fizzy drinks was greater for year 9 students than year 5. These responses indicate between a quarter and a third of school children are consuming fizzy drinks every day.

In response to the question “How often do you eat sweets, chocolate or chocolate bars?” children responded with the following answers –
There is less of an evident trend in the consumption of confectionary. Year 9 students appear to consume confectionary slightly more frequently than year 5 students. Over a quarter of both age groups eat confectionary every day.

A similar Health related behaviour survey in college students in Wakefield demonstrated that 56% of young people in further education drink sugary fizzy drinks daily.

Recommendation: Health promotion activities need to be strengthened to address the high number of children who drink sugary drinks and eat confectionary every day

Among adults intake of fruit and vegetables is below recommended levels for many in Wakefield District. In the Adult Health and Lifestyle survey in 2009, information was gathered on the number of portions of different types of fruit and vegetables eaten in a normal day. Overall 64.0% of residents responded that they were eating five or more portions of fruit and vegetables each day. 23.7% said they were having 3-4 portions, 8.2% 1-2 portions and 4.1% that they were having none. There is a marked variation by gender, with women more likely to be having five fruit and vegetables portions per day than men (68.1% women v 59.6% men).

The majority consider their current diet to be healthy. Overall 77.2% of males and 81.3% of females consider their diet to be very or fairly healthy. This could be influenced by response bias (where healthier individuals respond to health surveys). Notwithstanding this, there is a strong interest from many (67.5% for men, 62.5% for women) in eating a healthier diet. This interest is greater among lower socio-economic groups (of under-60 year olds) as demonstrated by the table below –
Figure 8 - Adults who wish to eat a more healthy diet by income group

<table>
<thead>
<tr>
<th>Income band</th>
<th>% who would like to eat a healthier diet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below £10K</td>
<td>77.5</td>
</tr>
<tr>
<td>£10K-£20K</td>
<td>73.1</td>
</tr>
<tr>
<td>£20K-£30K</td>
<td>74.2</td>
</tr>
<tr>
<td>£30K-£40K</td>
<td>69.8</td>
</tr>
<tr>
<td>£40K+</td>
<td>68.0</td>
</tr>
</tbody>
</table>

Source: Wakefield District Health and Lifestyle Survey 2009

With more than half the population in Wakefield meeting none of the nutritional guideline for fat, saturated fat, fibre, fruit, vegetables and protein, there is a high risk for tooth decay, oral cancer and other chronic diseases, negatively impacting oral health. Changes to create a community where everyone can access and afford healthy and sustainable food can hugely improve our resident’s health (Draft Wakefield Food Plan, 2014).

5.2.2 Food Poverty
With food price inflation and falling wages, food poverty is increasing, with the numbers of people accessing food banks for emergency food supplies rising dramatically. At St Catherine’s Community Centre in Agbrigg, demand has increased more than 11 fold in 1 year, from 109 food parcels distributed in 2012 to 1822 food parcels in 2013, and with distribution rates in January 2014 of 63 parcels per week. People receiving food parcels are from across the population including pensioners, working families and homeless people.

Those families and individuals who experience food poverty are more likely to consume a diet that is high in saturated fat, salt and sugar often from processed foods as they are seen to be more filling and energy dense. Meanwhile the consumption of fruit and vegetable which protect against ill health is falling with the lowest income households buying the least fruit and vegetables at an average of 2.9 portions per person per day in 2011, 14% less than in 2007 (Draft Wakefield Food Plan, 2014).

5.2.3 Alcohol
Alcohol is an important risk factor to consider in risks to oral health, both in terms of high sugar content leading to caries and alcohol (along with smoking) being a leading risk factor for oral cancers. When both tobacco and alcohol products are used together, the risks of oral cancers are multiplied rather than added. People who smoke two or more packets of cigarettes and drink four or more units of alcohol a day have a 35 times increased risk of
developing oral cancer compared with those who neither smoke nor drink more than two units of alcohol a day (Department of Health, 2009).

The North West Public Health Observatory provides twenty three statistical indicators of alcohol related harm broken down by district. Wakefield is worse than the regional average across many of the indicators including months of life lost, alcohol specific and attributable mortality, chronic liver disease, hazardous drinking, harmful drinking and binge drinking. (NWEPHO Local Alcohol Profiles, 2010; Wakefield Place Based Budgeting – Alcohol, 2011).

Almost a quarter (23.6%) of adults in Wakefield (over 70,000) consume at least twice the daily recommended amount of alcohol in a single drinking session. 21.4% of the population report engaging in increasing risk drinking and 7.5% of the population report engaging in higher risk drinking (Wakefield Lifestyle Survey, 2009).

5.2.4 Tobacco
Oral cancer and periodontal diseases are directly caused by tobacco. Nearly 1,900 people die from oral cancer each year in England and rates are increasing, especially among younger people (PHE, 2014). It also increases the severity and extent of periodontal diseases, tooth loss and poor post-operative wound healing, and leads to stained teeth, reduced taste sensation and halitosis (bad breath). Smokers are seven to ten times more likely to suffer from oral cancer than individuals who have never smoked (PHE, 2014).

Estimates of smoking prevalence vary depending on methods used. Smoking prevalence as reported in the Integrated Household Survey for NHS Wakefield is 24.8%, which is higher than the regional and national average (PHE Tobacco Control Profile, 2014). Local survey data from 2009 showed quite marked differences in adult smoking rates across the district, ranging from 29% of adults surveyed in Wakefield East ward and 28% in Knottingley ward, to just 12% in Wakefield Rural and Wrenthorpe and Outwood West wards (Wakefield Lifestyle Survey, 2009).

More recent SystmOne analysis paints a more extreme picture of the disparities within the district, with small pockets of deprivation having a current smoker prevalence as high as 40%. This 2013 analysis estimated 77,400 residents in Wakefield district smoked, according to GP records (www.wakefieldjsna.co.uk).

In a survey of people in the Yorkshire & Humber region, Wakefield had significantly more smokers (72.3% compared to 58.3%) who claimed to have not received any smoking cessation advice from any healthcare group (YHPHO Adult Oral Health Survey, 2008). A recent Cochrane systematic review found that smoking cessation in a dental setting could be effective in supporting individuals to quit (Carr and Ebert, 2012).

When both tobacco and alcohol products are used together, the risks of oral cancers are multiplied rather than added. The difference in risk can be as much as 35 times for groups with high alcohol and tobacco use. Wakefield is worse than the regional and national average across many of the indicators of harm from alcohol and with higher than average prevalence of smoking. There is therefore an increased risk of oral cancers in the Wakefield population, compared with other areas.
5.2.5 Oral Hygiene Practices
Major dental conditions of caries and periodontal disease can both be reduced by regular tooth brushing with fluoride toothpaste. The fluoride in toothpaste serves to prevent, control and arrest caries. The physical removal of plaque reduces the risk of inflammation. Some types of toothpaste contain ingredients which also reduce the initiation and progression of periodontal breakdown (Department of Health, 2009).

Over the past three Wakefield Health Related Behaviour surveys (2009, 2011 and 2013) primary school children (years 5 or 6) have been asked the question “How many times did you brush your teeth yesterday?” children responded with the following answers –

**Figure 9 - Frequency of tooth brushing of children by school year**

![Bar chart showing frequency of tooth brushing](chart)

Only around 3% of children reported not brushing their teeth at all, with nearly 80% of children reporting brushing their teeth at least twice. This appears reasonably stable over the last 4 years of conducting this survey.

**Recommendation:** The rates of tooth brushing twice a day in children need to be increased across the district.

5.2.6 Fluoride Use
Fluoride is a naturally occurring mineral found in water in varying amounts. It is also present in some food. During the early twentieth century, lower levels of tooth decay were found to be associated with certain fluoride levels in drinking water. This observation led ultimately to water fluoridation schemes, which adjust levels of the mineral in community water supplies in an effort to reduce tooth decay. In some parts of England the level of fluoride in the public water supply has been adjusted to one mg per litre (one part per million). Currently, around six million people live in areas with fluoridation schemes.

A recent national report (Public Health England, 2014) found that on average, there are 15% fewer five-year olds with tooth decay in fluoridated areas than non-fluoridated areas. When deprivation and ethnicity (both important factors for dental health) are taken into account,
this rises to 28% fewer five-year olds have tooth decay in fluoridated areas than non-fluoridated areas. In addition, there are 11% fewer 12-year olds with tooth decay in fluoridated areas than non-fluoridated areas. When deprivation and ethnicity are taken into account, this rises to 21% fewer 12-year olds have tooth decay in fluoridated areas than non-fluoridated areas. Overall, the reduction in tooth decay in children of both ages in fluoridated areas appears to be greatest among those living in the most deprived local authorities.

The beneficial effects of water fluoridation are clearly demonstrated in some local authority areas with otherwise poor health outcomes. Some of the lowest rates of tooth decay in 5 year olds amongst the 50 local authorities in the PHE North region are found in Hartlepool (1st), Gateshead (7th), Newcastle (9th) and North Tyneside (11th), which all have fluoridated water (naturally in Hartlepool's case). These tooth decay rates are associated with the water fluoridation in those areas and buck the trend of otherwise poor health outcomes in each of these districts.

Wakefield is not a water fluoridated area (naturally or man-made). The Local Authority Social Care and Health Overview and Scrutiny Committee considered water fluoridation in 2007.

“The Committee interviewed expert witnesses and received correspondence from individuals and organisations. Members considered available information in relation to the fluoridation of water, but found the research evidence of insufficient quality to allow confident statements to be made regarding safety and efficacy.” (Wakefield SCHOSC, 2007)

Given the recent PHE report that provides evidence to support the claim that water fluoridation is safe and effective, the quality of the evidence has improved since Wakefield SCHOSC reviewed this issue in 2007.

**Recommendation:** In light of the recent evidence published by Public Health England, Wakefield Council Overview and Scrutiny Committee (Social Care and Health) could reconsider a local water fluoridation scheme in order to improve the oral health of children in the district.

5.3 Social and financial impacts

*Please see PHE West Yorkshire Regional OHNA (Chapter 5).*

5.4 Dental Anxiety and Phobia

Dental anxiety is measured on a continuum from low anxiety to high anxiety and is associated with fear and recognisable symptoms of anxiety that are specifically associated with anticipated or actual dental care (Öst and Skaret, 2013). Dental Phobia is “a disproportional fear of (invasive) dental procedures” (Doering et al, 2013; p584) and is a recognised phobia classified within the Diagnostic and Statistical Manual of Mental Disorders (DSM IV). Dental phobia is associated with high levels of dental anxiety. Both conditions are associated with impaired quality of life associated with oral health, reduced help seeking
behaviours, reduced attendance for dental care and increased dental caries, pain and oral dysfunction (Öst and Skaret, 2013).

The latest adult dental health survey in the UK in 2009 (using the Modified Dental Anxiety Scale on those that had attended a dentist), reported that 36% of participating adults had moderate dental anxiety (MDA score 10-18) and 12% had extreme dental anxiety (MDA score 19+). Higher rates of extreme dental anxiety were associated with being female, working age groups and lower socio-economic groups (NHS Information Centre, 2010). The Yorkshire and Humber Adult Dental Health Survey in 2008 identified when being scared of the dentist was a barrier to accessing routine or urgent dental care. Of Wakefield respondents who indicated they had problems accessing dental care (23.1% for routine care, 20.6% for urgent care), 21.0% stated being scared was a barrier to access routine care and 9.5% stated being scared was a barrier for access to urgent dental care (NHS Yorkshire and the Humber, 2008).

The prevalence of high dental anxiety has been estimated across different populations over the last 50 years with consistent findings with estimated prevalence between 3% and 10% of the population (Öst and Skaret, 2013). Dental phobia prevalence is estimated to be between 3% and 5% of the population (Floor et al, 2009).

These prevalence estimates suggest that in Wakefield district between 10,000 and 33,000 people may experience high dental anxiety and between 10,000 and 16,000 people may meet the diagnostic criteria for dental phobia.

A meta-analysis of the efficacy of behavioural interventions for dental fear (Kvale et al, 2004) found moderate evidence of reduction in fear and sustained dental attendance beyond the intervention. They estimated that 77% of those receiving the interventions continued to engage with dental care for at least 4 years afterwards. It concluded that behavioural interventions have a positive effect on dental fear, and should, therefore, be incorporated in any treatment of highly fearful patients.

The Wakefield Community Dental Service sees phobic patients currently in community clinics, although this may change if the current commissioning review recommends changes in service provision. The service offers longer appointments to try and overcome fears through discussion, behavioural management strategies and inhalation sedation (gas and air). Sometimes the service can treat patients under general anaesthetic if they have other special needs, or it can refer to maxillofacial department (at Mid Yorks Trust) for extractions.

Wakefield Community Dental Service does not provide intravenous (IV) sedation as there are currently no IV sedation trained nurses and insufficient numbers of trained dentists to offer this service, if made available on the NHS.

Other localities have access to cognitive behavioural treatment as part of a designated pathway for anxious/phobic patients before, or while, they are seen in the Community Dental service (e.g. Worcestershire, Wolverhampton, Sheffield).

Recommendation: Clinical pathways and services for people with dental phobia and high dental anxiety should be reviewed locally in order to address this treatment gap.
6.0 Epidemiology of oral diseases

6.1 National adult and child dental health

6.1.1 Historical National Dental Health Survey Data 1998 - 2006

In 2008 Wakefield PCT produced an oral health strategy which included epidemiological data for Wakefield from national data sets. Although these rates cannot be compared with current data as the sampling process changed with the need for active consent rather than passive consent from parents/guardians, they still give some background trend information which is informative.

The average number of dental caries (DMFT) per 5 year old child in Wakefield between 1998 and 2006 was compared to Yorkshire and national figures as follows –

Figure 10 - Comparison of dmft in 5-year old children in Wakefield District from 1996 to 2006

A national trend of reduction in average caries per child was not clearly seen in the data for Yorkshire or for Wakefield, which displayed fluctuating trends. A similarly fluctuating local trend of caries free 5 year olds were also seen in the period compared with a more consistent trend nationally, as demonstrated below –

The first oral health survey of 11 year olds was conducted in 2004/5 so the 2008-12 Wakefield report only contained prevalence data for this year and not trend data. Nevertheless, significantly worse oral health was seen in Wakefield (old separated PCTs of East and West Wakefield) compared with Yorkshire and England as the graph below indicates –

**Figure 12 - Comparison of DMFT in 11-year old children in Wakefield District**
showed a worsening trend more in line with the rest of Yorkshire for the period between 1995 and 2003. The data concerns average DMFT per child –

**Figure 13 - Comparison of decayed teeth (DMFT) in 14 year old children**

From all these data sets, it can be concluded that for the period 1998 to 2006 more Wakefield children had poor oral health compared to their regional and national counterparts. This was the case for all ages of the surveys (5, 11 and 14 year olds). There did not seem to be a clear trend in the period for any age group compared to clear national trends of improvements in oral health. This demonstrates a widening gap between oral health of Wakefield children and children in England overall.

6.1.2 National Dental Health Survey Data for 5 year olds (2008 – 2012)
The theme of worse oral health for more Wakefield children than their national counterparts continues in the recent survey data for each age group. There is also some evidence that the gap between local and national health has continued to widen over the last 5 years.

**Percentage of children with some decayed teeth**

More Wakefield children aged 5 years old have some dental decay (DMFT>0), compared with their national and regional counterparts.

<table>
<thead>
<tr>
<th>Area</th>
<th>2007-8 Survey</th>
<th>2011-12 Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wakefield</td>
<td>33.8%</td>
<td>40.6%</td>
</tr>
<tr>
<td>Yorkshire and Humber</td>
<td>38.7%</td>
<td>33.6%</td>
</tr>
<tr>
<td>England</td>
<td>30.9%</td>
<td>27.9%</td>
</tr>
</tbody>
</table>
In the 2011-12 survey this gap was statistically significant which means this difference is not down to chance or natural fluctuations in oral health. The 5 year olds in Wakefield are now 1.5 times more likely to have some dental decay than 5 year olds across England.

For an average group of 100 Wakefield children aged 5, there would be 41 with some decayed teeth, compared with 28 from an average group of 100 children from England. In an average group of 100 children from Yorkshire and Humber, 34 would have some decayed teeth.

The percentage of Wakefield children aged 5 with some dental decay is statistically significantly higher than 5 year olds across England. Whereas regionally and nationally there was a reduction in this figure, in Wakefield there was an increase between 2008 and 2012 from 33.8% to 40.6% of 5 year olds. The England average reduced between 2008 and 2012 from 30.9% to 27.9% of 5 year olds.

**Figure 14 - Percentage of 5 year olds with some dental decay (DMFT>0)**

Source: National Dental Epidemiology Programme for England (Public Health England)
In comparison with other West Yorkshire districts, percentage of 5 year olds with some dental decay in Wakefield has increased whereas all other districts (apart from Kirklees) have decreased over the time period. Although this is a concerning trend which is demonstrated in the figure above, it should be noted that the difference in percentage with some dental decay for Wakefield 5 year olds between 2007-8 and 2011-12 is not statistically significant. Therefore the true value in the population of 5 year olds may not have changed at all, or may have even decreased. (95% confidence interval for 2007-8 is 30.0 to 37.7 and the 95% confidence interval for 2011-12 is 33.5 to 47.6. As these intervals include some of the same values it cannot be inferred that the difference is statistically significant and so this change could be as a result of chance).

Mean number of decayed teeth per child

The average number of dental caries (mean DMFT) per 5 year old child is also statistically significantly higher in Wakefield children than Yorkshire and Humber and England in the 2011/12 survey. The mean number of decayed teeth in Wakefield was 1.66 compared with 1.23 in Yorkshire and Humber and 0.94 in England.

According to the Public Health Outcomes Framework, amongst the 50 local authorities across the North of England PHE region, Wakefield district ranks 41st for mean decayed teeth in 5 year olds.
In comparison with other West Yorkshire districts, mean DMFT in Wakefield has increased whereas all other districts (apart from Calderdale) have decreased over the time period. Although this is a concerning trend which is demonstrated in the graph below, it should be noted that the difference in mean DMFT for Wakefield 5 year olds between 2007-8 and 2011-12 is not statistically significant. Therefore the true value in the population of 5 year olds may not have changed at all, or may have even decreased. (95% confidence interval for 2007-8 is 1.17 to 1.57, the 95% confidence interval for 2011-12 is 1.27 to 2.04. As these intervals include some of the same values it cannot be inferred that the difference is statistically significant and so this change could be as a result of chance).
The largest contribution of the gap in mean DMFT between Wakefield and England in the 2011-12 survey is the difference in obviously decayed teeth (d₃t). The Wakefield mean number of obviously decayed teeth is 1.32 compared with the England mean of 0.72. This is statistically significant, whereas the difference in missing teeth (mt) and filled teeth (ft) between Wakefield and England is not.

6.1.3 National Dental Health Survey Data for 12 year olds (2008-9)

Since the new sampling format of active consent from parents/guardians there has only been one national survey undertaken for 12 year olds in 2008-9. This data set also provides evidence of worse oral health for Wakefield children compared with their national counterparts. Statistically significantly more 12 year old children in Wakefield have decayed teeth (DMFT>0) than their England counterparts (40.0% v 33.4%). However this is less than the regional average (44.7%), although this is not statistically significantly less.

For an average group of 100 Wakefield 12 year old children, there would be 40 with some decayed teeth compared to an average group of 100 England 12 year old children of which 33 would have some decayed teeth.
The mean number of decayed teeth (DMFT) is also higher for Wakefield 12 year olds than their England counterparts (1.10 v 0.74). This is statistically significant, which means this difference is not down to chance or expected fluctuations in oral health.

For an average group of 10 Wakefield children aged 12, there would be 11 caries between them, compared with an average group of 10 children from England having 7 caries between them and an average group of 10 children from Yorkshire and Humber having 11 caries.

This difference is driven by obviously decayed teeth, filled teeth and to an extent missing teeth (due to decay). This contrasts with only obviously decayed teeth driving the differences for Wakefield 5 year olds. So it appears that as children are getting older in Wakefield the differences in rates of filled and missing teeth are also becoming noticeably worse than England as a whole.
6.1.4 National Dental Health Survey Data for 3 year olds (2013)
For the first time in its history the national dental epidemiological survey has undertaken a survey on 3 year olds across England in 2013. This followed similar methodology to surveys in 5 year olds and 12 year olds.

The percentage of Wakefield 3 year olds with any decayed teeth was 19.8% which was the highest percentage across Yorkshire and Humber. It was also statistically higher than the England average of 11.7% (Wakefield 95% CI - 12.1% to 27.5%, England 95% CI - 11.4% to 12.0%).

So for an average group of 100 Wakefield 3 year olds, 20 would have some decayed teeth compared to an average group of England 3 year olds, of which 12 would have some decayed teeth.

The percentage of Wakefield 3 year olds with any decayed teeth was statistically higher in Wakefield (19.8%) than some other Yorkshire local authorities (Barnsley 11.8%, Doncaster 8.9%, East Riding of Yorkshire 3.9%, North Lincolnshire 8.1%, North Yorkshire 8.8%, Rotherham 11.5%, Sheffield 8.4% and York 6.9%) but was not statistically higher than the Yorkshire and Humber average (12.6%).

**Figure 20 - Percentage of 3 year olds with any decayed teeth by Y&H Local Authority 2013**
The mean number of decayed teeth (DMFT) per Wakefield 3 year old was 0.51 teeth. This compared with an England mean of 0.36 teeth and a Yorkshire and Humber mean of 0.39 teeth. However, the difference between Wakefield mean and national and regional means or with other Y&H authorities was not statistically significant.

6.1.5 National Survey of Orthodontic Need in 12 year olds
Orthodontics is an elective procedure to correct anomalies in growth of the teeth and jaws and is normally commenced after the eruption of all the permanent teeth except the third molars (wisdom teeth), at approximately 12 to 14 years old. Orthodontic treatment need is assessed using the Index of Orthodontic Treatment Need (IOTN).

As part of the 2008-9 NHS Dental Epidemiology Programme for England, a sample of 12 year olds were examined for need of orthodontic treatment. In Wakefield, 28 out of the 307 children examined (9.1%) were already wearing an orthodontic appliance (brace). A further 94 of the 307 children examined (30.6%) met the IOTN orthodontic need criteria, but were not wearing an appliance. Of these 94 children, 56 thought their teeth needed straightening and were prepared to wear a brace (18.2% of all children examined).

Therefore it is estimated that of all the 12 year old children in Wakefield who need a brace and would be prepared to wear one (estimate = 708), only half (estimate = 354) are currently benefitting from an orthodontic appliance. This is based on mid-2008 population estimates for 12 year olds and so would be slightly larger now with the growth in this age group across Wakefield.

Even though 50.0% of cases, represents an unsatisfactory treatment rate, it is better than England (41.2%) and regional (30.4%) estimated treatment rates.

Recommendation: Local input should be provided to NHS England review of orthodontic services and findings considered locally.

6.1.6 Sample sizes for Epidemiological Surveys in Wakefield
The data produced by the national epidemiological surveys, are the most robust evidence of rates of dental caries in the population. However, their statistical validity relies on their sample sizes being large enough to represent the whole population well enough to be able to draw inferences from the data. The 5 year old epidemiological survey in Wakefield did not use a large sample size in comparison with other areas. The table below indicates the sample size in comparison with other areas –
<table>
<thead>
<tr>
<th>Area</th>
<th>5 year old population estimate (2011)</th>
<th>5 year olds examined in 2011-12 survey</th>
<th>% of 5 year olds examined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bradford</td>
<td>8,074</td>
<td>1,293</td>
<td>16%</td>
</tr>
<tr>
<td>Calderdale</td>
<td>2,532</td>
<td>255</td>
<td>10%</td>
</tr>
<tr>
<td>Kirklees</td>
<td>5,476</td>
<td>274</td>
<td>5%</td>
</tr>
<tr>
<td>Leeds</td>
<td>8,928</td>
<td>1,435</td>
<td>16%</td>
</tr>
<tr>
<td>Wakefield</td>
<td>3,841</td>
<td>189</td>
<td>5%</td>
</tr>
<tr>
<td>Yorkshire and the Humber</td>
<td>63,667</td>
<td>12,695</td>
<td>20%</td>
</tr>
<tr>
<td>England</td>
<td>635,925</td>
<td>133,516</td>
<td>21%</td>
</tr>
</tbody>
</table>

The relatively low sample size contributed to the lack of certainty that could be made in drawing conclusions from this data set. Although the trends look concerning (an increasing number of Wakefield 5 year olds having some decayed teeth), it cannot be stated strongly as there is uncertainty in the data due to the inadequate sample size.

**Recommendation:** Future epidemiological surveys in Wakefield should ensure a large sample size, in order to produce results that can be analysed with more certainty.

### 6.2 Oral Health of Adults

*Please see PHE West Yorkshire Regional OHNA (Chapter 5). Summary findings –*

- The oral health of adults has improved significantly over the last 40 years with more of the population retaining their natural teeth throughout their lifetime.
- In Yorkshire and Humber, 30% of adults had tooth decay and 2% had severe gum disease.
- Men from materially deprive backgrounds were more likely to experience higher levels of tooth decay and gum disease but least likely to visit a dentist.
- People in Wakefield were more likely to report a perceived need for treatment than other areas.
- People in Yorkshire and Humber were more likely to wear a denture than nationally.

### 6.3 Oral Health of Vulnerable Groups

*Please see PHE West Yorkshire Regional OHNA (Chapter 5). Summary findings –*

- Information describing the oral health of vulnerable groups locally is limited.
- Children with learning disabilities are more likely to have teeth extracted than filled and have poorer gum health.
• Wakefield has significantly more adults with learning disabilities known to GPs relative to the national average.
• Adults with learning disabilities are more likely to have poor oral health than the general population.
• Adults with learning disabilities living in the community are more likely to have poorer oral than their counterparts living in care.
• Approximately a quarter of the population experiences some kind of mental health problem in any one year. However, there is no local information on the oral health needs of this group.
• Vulnerable adults in residential care are more likely to have access to dental services than those in the community.
• Prisoners experience poorer oral health than the general population. This oral health needs assessment does not consider this group.
• Homeless people are more likely to have greater need for oral healthcare services than the general population.
• Bariatric people may be at higher risk of oral disease. Bariatric dental services are available in all the local authority areas apart from in Bradford.
• Looked after children are likely to have greater oral health needs than their peers.

7.0 Oral health care services

Please see PHE West Yorkshire Regional OHNA (Chapter 6). Summary key issues –

• The feasibility of undertaking a health equity audit of access to dental services should be explored in view of variations in availability of and access to dental services across and within local authority areas.
• Dental practices need to be supported to ensure that ethnicity data is captured on dental service activity forms to inform future needs assessment and health equity audits.
• Dental practices need to be supported to ensure that evidence-based guidance on fluoride varnish applications and recall intervals is implemented in practices. Key performance indicators to encourage evidence-based practice should be considered for inclusion in any new dental contracts.
• Current domiciliary provision is likely not to be sufficient to meet current and increasing demand. Equity of provision should be confirmed.
• NHS England may wish to consider commissioning or undertaking a more in-depth review of sedation service provision to support the development of a consistent service model for anxious patients that incorporate sedation services and behaviour management techniques.
• Building on the review of the community dental services in West Yorkshire, information should be collated to support commissioning intentions to ensure more vulnerable patient groups with more complex and special care needs are able to access appropriate care.
• To help inform a more in-depth needs assessment for special care dental services in preparation for implementation of the national commissioning guide, robust activity indicators should be considered, for incorporation into current community dental service contracts together with the development of a managed clinical network in special care dentistry.
NHS England may wish to consider commissioning or undertaking a more in-depth review of general anaesthesia service provision to support the development of accessible, high quality, safe and patient centred services.

To identify and help address the gaps in provision of primary care specialist oral surgery and restorative services in West Yorkshire a review should be considered. This should be in line with the forthcoming NHS commissioning guidance.

A more detailed orthodontic needs assessment including a review of provision of orthodontic services across West Yorkshire against the commissioning framework due to be published in 2015. It is important to explore ways of providing more equitable access; and to inform the development of a service model with a consistent UOA rate that incorporates key performance indicators including PAR scoring and that is delivered by specialists.

NHS England may wish to consider working with secondary care providers to review secondary care local tariffs and develop and agree standard coding for secondary care dental activity to contain spend on secondary care and ensure value for money.

NHS England may wish to consider working with local clinical networks, PHE and providers to develop and incorporate quality assurance into secondary care contracts and in preparation for implementation of the soon to be published NHS England commissioning guides.

7.1 General dental services
Please see PHE West Yorkshire Regional OHNA (Chapter 6).

7.1.1 Access to Dental Practices in Wakefield
The Wakefield And District Health and Lifestyle Survey 2009 provides a rich source of data on the health and behaviour of adults aged 16+ resident in the Wakefield area. In total over 25,000 postal responses were received and analysed. Three questions within the survey related to access to dentists across the district.

In answer to the question “Are you registered with a dentist?” the following responses were given -

<table>
<thead>
<tr>
<th>B17 Are you registered with a dentist?</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes-registered as NHS patient</td>
<td>62.00%</td>
</tr>
<tr>
<td>Yes-registered as private patient</td>
<td>13.12%</td>
</tr>
<tr>
<td>Yes-not sure if NHS or private patient</td>
<td>2.70%</td>
</tr>
<tr>
<td>Not registered</td>
<td>19.31%</td>
</tr>
<tr>
<td>Don't know</td>
<td>2.88%</td>
</tr>
</tbody>
</table>
In answer to the question “When was your last visit to the dentist for a regular check-up?” the following responses were given -

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 6 mths ago</td>
<td>55.94%</td>
</tr>
<tr>
<td>6 mths to a year ago</td>
<td>14.74%</td>
</tr>
<tr>
<td>1-5 years ago</td>
<td>14.23%</td>
</tr>
<tr>
<td>More than 5 years ago</td>
<td>13.08%</td>
</tr>
<tr>
<td>Have never been</td>
<td>2.02%</td>
</tr>
</tbody>
</table>

In answer to the question “When was your last visit to the dentist for emergency treatment?” the following responses were given -

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 6 mths ago</td>
<td>10.56%</td>
</tr>
<tr>
<td>6 mths to a year ago</td>
<td>6.34%</td>
</tr>
<tr>
<td>1-5 years ago</td>
<td>20.78%</td>
</tr>
<tr>
<td>More than 5 years ago</td>
<td>24.57%</td>
</tr>
<tr>
<td>Have never been</td>
<td>37.75%</td>
</tr>
</tbody>
</table>

The responses to these survey questions indicate that approximately 4 out of 5 people in Wakefield are registered with a dentist and that 7 out of 10 have had a routine check-up in the last year. However 1 in 6 respondents report they had needed emergency treatment at the dentist in the last year.

7.2 Community dental services
Please see PHE West Yorkshire Regional OHNA (Chapter 6).
7.3 Unscheduled including out of hours dental services
NHS 111 is a free telephone service introduced nationally to make it easier for people to access local health and social care services when they have an urgent need. In Yorkshire and the Humber, this service is provided by Yorkshire Ambulance Service (YAS) NHS Trust. It provides a general number for people to call when their need is urgent but not considered life-threatening (999). It is available 24 hours a day, 7 days a week and 365 days a year and is able to receive calls for unscheduled dental problems.

The calls to NHS 111 from Wakefield (CCG responsible population not resident population) have been analysed for a 10 month period between April 2013 and February 2014. A total of 7,942 calls were made in the 10 month period. Times of day were analysed which demonstrated a sharp peak of calls between 8am and 10am which gradually tailed off over the course of the day (see Figure ??).

Figure 21 - Count of NHS 111 dental calls per 15 minute interval of each day of the week (April 2013 to February 2014)

Further analysis of the callers indicates that the largest age category of callers were aged 19-30. The number of callers gradually reduces with increasing age groups (Figure ??). Over half of all callers were between the ages of 19 and 40 (n=4,443).
After analysis of the postcodes of these callers, the call rate per 1000 population were calculated for each Lower Super Output Area (LSOA). This call rate varied per LSOA between 5 and 63 calls per 1000 population. The call rates for each LSOA were compared with deprivation scores (IMD, 2010) and were found to have a moderately strong association. Areas with higher deprivation tended to call NHS 111 with dental problems more often.
The following map illustrates the call rates to NHS 111 by LSOA for the more highly populated areas of the district. The towns with the areas of highest call rates to NHS 111 are Wakefield, Normanton, Castleford, Knottingley, Hemsworth and Fitzwilliam. Fitzwilliam is of particular note as there is not currently a dental practice located in Fitzwilliam.

It is possible this data gives an indication of the use and knowledge of NHS 111 as a service within different geographical areas of the district, rather than need of unscheduled dental care.
Calls to 111 with a dental related query during the 2013-14 financial year
Rate per 1,000 population
Data calculated at LSOA level
An urban area mask has been applied
7.4 Hospital and Specialist dental services
Please see PHE West Yorkshire Regional OHNA (Chapter 6).

7.5 Accident and Emergency
A+E services are provided locally by Mid Yorkshire Hospitals NHS Trust at Pinderfields Hospital in Wakefield, Pontefract Hospital and Dewsbury and District Hospital (which is based in Kirklees council area but serves some of the Wakefield population).

Using the SYMPHONY database system, a data query was undertaken by MYHT Knowledge Management Service at the request of the public health team at the council. The following results were found for the period 2010/11 to 2013/14 for residents of Wakefield District.

<table>
<thead>
<tr>
<th>Year</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A+E attendances for oral conditions</td>
<td>689</td>
<td>750</td>
<td>790</td>
<td>836</td>
<td>3065</td>
</tr>
</tbody>
</table>

Of the 3,065 presentations for oral conditions at A+E over the 4 years, there was variation on which day of the week attendances were made, with Thursday having nearly half the attendances on Sundays.

Figure 24 - Number of A+E presentations for oral conditions by day of the week in 2010-14

Times of day of the presentations at A+E followed the common pattern for all A+E attendances over the 24 hour period. Peak attendances were around 6pm with a smaller peak at 12 noon. Most attendances were during the working day.
Figure 25 - Number of A+E presentations for oral conditions by hour of the day in 2010-14 (24 hour clock)

Over the 4 year period, 43.9% of A+E attendances were females and 56.1% were males. One possible explanation for this could be higher proportions of women attending dentists and receiving interventions earlier than men. Women are then less likely to need to attend A+E. While female presentations have remained stable, male presentations have increased significantly over the last three years, as can be seen in the figure below.

Figure 26 - A+E oral presentations by sex between 2011/12 and 2013/14

For the 3,065 presentations over the 4 years of data, the percentage of A+E attendances by age group remained fairly static. The figure below indicates the highest age bands were 16-25 and 26-35. Just over 1 in every 6 attendances were children between 0 and 15 years old.
Of the 3,065 presentations at A+E for oral conditions between 2010 and 2014, the main diagnosis groups recorded were ‘Dental abscess/infection’ (45.2%), ‘Dental MaxFac’ (14.6%), ‘Dental Pain’ (11.9%) and ‘Other ENT condition’ (11.1%). 5.7% were unknown or recorded in 32 other categories (including some oral conditions but many which are not).

For children between 0 and 15 years old the distribution of presentations slightly changes with proportionately less presentations for abscess and infection and more presentations for injuries and accidents (broken teeth and dental maxfac) when compared to all oral presentations.
Various discharge outcomes were recorded for the 3,065 presentations. The most common was ‘Referral to a dentist’ (n=999), ‘Discharged no follow up’ (n=548), ‘Discharged to GP’ (n=548) and ‘Admitted to MYHT ward’ (n=507). The percentages of discharge outcomes for all oral conditions are presented in the figure below.

The most frequent diagnosis categories which resulted in a referral to a dentist (n=999) was ‘Dental abscess/infection’ (n=541), ‘Dental Pain’ (n=161) and ‘Dental MaxFac’ (n=140).
Recommendation: Emergency and urgent dental care pathways should be reviewed to optimise access for Wakefield residents

8.0 Costs
Please see PHE West Yorkshire Regional OHNA (Chapter 6).

9.0 Access to Services
Please see PHE West Yorkshire Regional OHNA (Chapter 6).

10.0 Dental Public Health services
Please see PHE West Yorkshire Regional OHNA (Chapter 7). Summary key issues -

- Local authorities should ensure that oral health needs are considered in JSNAs and Health and Wellbeing Strategies.
- All local authorities West Yorkshire should review their oral health improvement programmes in line with Commissioning Better Oral Health and NICE guidance.
- Local authorities may wish to consider engaging with partners integrating commissioning across organisations and across bigger footprints to support the efficient management of limited resources.
- All local authorities in West Yorkshire should ensure that contracts are supported by service specifications which detail a process of assuring quality of programmes.
A combination of evidence based universal and targeted activities are required to support reducing inequalities in oral health. Upstream interventions should be complemented by downstream interventions.

Local authorities should consider the case for water fluoridation in the context of local needs and the range of oral health improvement programmes currently commissioned and with reference to Commissioning Better Oral Health and NICE guidance.

Consideration should be given to ensuring programmes effectively support improving the oral health of more vulnerable adults group.

Evaluation should be an integral part of all oral health improvement programmes to guide future commissioning.

In addition, local authorities should consider integrating oral health improvement into existing commissioned programmes.

Oral health improvement should be an integral part of the work of health visitors and schools nurses and should be included in the service specification for these services.

Service specification for care homes should include a responsibility for oral health that incorporates an oral health assessment on entry, daily mouth care in care plans for residents and regular access to an NHS dentist.

A MECC trained dental workforce should be developed across West Yorkshire.

Local authorities may wish to explore using cost benefit analysis tools to evidence effective use of resources to support improvements in oral health.

10.1 Wakefield Oral Health Promotion Service

Wakefield Council commissions an Oral Health Promotion service from Mid Yorkshire Hospitals NHS Trust in order to address the need for dental public health initiatives to support vulnerable groups and tackle oral health inequalities in the district. The service is being re-tendered in 2014/15 by the Council. The current aims of the service (which may change in preparation for commissioning a new service and following this needs assessment) are to –

- Provide a service in accordance with current evidence-base for prevention of oral diseases and promotion of oral health.
- Develop a high quality oral health promotion service
- Work in partnership with organisations/partners to improve oral health by embedding oral health practice and principles in a wide range of organisations
- Improve diet and nutrition and thereby help to reduce obesity through oral health education programmes via the common risk factor approach
- Reduce smoking (and alcohol) through oral health programmes by encouraging smoking cessation via the common risk factor approach
- Increase access to oral health provision of groups more vulnerable to poor oral health.
- Optimise exposure to fluorides through various vehicles
- Help to train and develop the health and social care workforce
- Improve access to dental services.

The key programmes delivered by the service are –
The service is staffed by an Oral Health Promotion Manager (0.5 WTE), an Oral Health Trainer (0.8 WTE), 3x Dental Nurses (Oral Health Promotion - 2.5 WTE) and an Administration Assistant (0.4 WTE).

10.1.1 Brushing for Smiles
Children who start brushing their teeth in infancy are less likely to experience tooth decay than those who start brushing later. Since 2001, free packs including a toothbrush, toothpaste, feeder cup and information resources are distributed to all children in Wakefield at their 6 month development check by Health Visitors. Each pack has a cost of £1.66 + delivery. 4,500 children benefit from this pack each year in Wakefield. The oral health promotion service source and distribute these packs to the health visiting teams across Wakefield.

10.1.2 Just Brush
Just Brush, is a nursery based daily tooth brushing intervention aimed at improving oral health and reducing inequalities. The logistics of the programme closely followed the National Standards for Tooth brushing Programme in Scotland - Childsmile

This programme was piloted in Ginmill Infants School. On its evaluation and success the programme was offered to other schools where children have the highest levels of disease in Wakefield and using the Free School Meal Indicator (FSM %) as a measure of deprivation.

The scheme continues in five primary schools across Wakefield (Redhill Infant School, Castleford; Heath View Community Primary School, Wakefield; Havercroft Junior and Infant School, Havercroft; St. Michaels C of E Primary School, Wakefield and St Giles Infant and Junior School, Pontefract) with 341 children currently participating. Between September 2009 and March 2014, 1,741 children have participated in all in 14 schools.

10.1.3 Work together–Smile forever
This programme is a community based fluoride varnish application programme to support the reduction in oral health inequalities and achieve sustainable improvements in oral health.

The oral health promotion service works in partnership with all Children’s Centres district wide to administer this programme. Awareness sessions are held within the centres to identify children aged 2-5 who would benefit. Subject to parental consent children are offered fluoride varnish application twice a year. Each application costs of £1.75. A care pathway has been developed with the General Dental Service and all children who attend a dentist regularly are discharged to their care for future applications. Those children that do not are given contact numbers of practices in the area that are accepting new patients. To date all 23 children's centres participate in this initiative and a number of school nursery classes. In 2013 the following was delivered in this programme –
<table>
<thead>
<tr>
<th>Setting</th>
<th>Total no. of children with consent obtained</th>
<th>1st Application Fluoride Varnish</th>
<th>2nd Application Fluoride Varnish</th>
<th>Patients signposted to dentist when not registered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Centres</td>
<td>414</td>
<td>262</td>
<td>147</td>
<td>146</td>
</tr>
<tr>
<td>School Nurseries</td>
<td>697</td>
<td>518</td>
<td>174</td>
<td>223</td>
</tr>
</tbody>
</table>

### 10.1.4 Clinical Prevention

Preventive Dental sessions (PDS) are held at 3 Community Dental Service clinics within the district. This involves one to one oral health advice given to patients as required by the treating Dental Practitioner. Advice clinics are also offered as a part of the General Anaesthetic (GA) and Special Needs General Anaesthetic (SNGA) assessment clinics.

In addition the service delivered training in 2013/14 regarding PEG fed patients (30 participants), Student HV training (13 participants) and training to School Staff (3 participants).

### 10.1.5 Oral Health Training Programmes

Several training programmes are run for different age groups which include -

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents of 0-3 yr olds</td>
<td>‘Your Tots Teeth’ - Delivered in a formal and informal format directly to parents and carers of new babies and young children.</td>
</tr>
<tr>
<td>4-5 year olds</td>
<td>Pre Five Familiarisation Programme - Delivered to children attending lower foundation with a request to invite parents to attend.</td>
</tr>
<tr>
<td>School aged 5 -11 yrs old</td>
<td>Oral health Sessions to correspond with the curriculum level of the age group. Delivered in conjunction with a Healthy School event where other health professionals are present. Resource loan service.</td>
</tr>
<tr>
<td>School aged 11-16 yrs old</td>
<td>Oral Cancer Awareness – this course is presented to year groups or classes as part of their PHSE session, covering oral cancer, smoking, alcohol and oral piercings. National campaigns providing oral health input.</td>
</tr>
</tbody>
</table>
10.1.6 Oral Health for Adults with Learning Disabilities
All residential settings for people with learning disabilities in Wakefield are offered training for their staff on oral health. This 2.5 hour course covers care of dentures, natural teeth, gum disease, ulcers, mouth cancer and effects of medication on the mouth. A certificate of Attendance is given on completion. In 2013/14, four sessions were delivered by the service to 37 staff members.

10.1.7 Oral Health for Older People
All nursing homes in Wakefield are offered training for their staff on oral health. This course covers care of natural teeth and dentures, common mouth conditions, ulcers, mouth cancer, dry mouth and effects of medication on the teeth. A certificate of Attendance is given on completion. In 2013/14, seven sessions were delivered to 48 staff members.

Community Groups can also access training. This is most often requested by Age Concern, Food and Community Workers or Health Development Workers for older ladies groups, older mens groups, stroke group, diabetes group etc. This course covers the main causes of poor oral health, gum disease, effects on the mouth of smoking, care of dentures and to encourage dental visits.

13.1.8 Building Smiles in the South East
An oral health pilot programme is currently running in the South East of Wakefield District as part of the Health Visiting Teams Building Community Capacity agenda.

Building Smiles in the South East is an initiative which aims to produce a template of oral health practice that will be incorporated into the Health Visiting role for all teams across the district. The template will encourage Health Visitors to take the opportunity to discuss key dental health messages at various stages throughout a child’s health development programme.

10.2 Practiced based Oral Health Promotion
Dentists have a role in offering and providing fluoride varnishes in children as a preventative measure. Delivering Better Oral Health (Department of Health, 2009) advises that all children and young people should have two fluoride varnish applications per year. Compared with other West Yorkshire areas, dentists in Wakefield record less courses of treatment delivered that include fluoride varnish (see Figure???). Kirklees and Bradford have noticeably higher rates of fluoride varnish applications. Given the high rates of dental caries in Wakefield amongst children, higher rates of fluoride varnish applications by dentists could make a significant contribution to improving oral health.
**Figure 32 - % of all dental courses of treatment for children that included fluoride varnish**

Source: HSCIC – NHS Dental Services

**Recommendation - Prevention activities such as fluoride varnish applications and health advice should be offered routinely by all dentists in the district.**

**11.0 Public views/engagement**

*Please see PHE West Yorkshire Regional OHNA (Chapter 8).*

In order to understand the local situation in Wakefield regarding oral health in more vulnerable groups, a series of local surveys were conducted during 2014. The groups that were selected for these local surveys were groups identified as priorities in the Wakefield Health and Wellbeing Strategy (2013-16). The Wakefield Oral Health Steering Group agreed on the following groups to undertake local surveys –

- Early Years (Parents of pre-school children)
- Mental Health (Service users of secondary mental health services)
- Older People (Aged over 50 years old)
- Residential care (home managers)
The following sections of the needs assessment outline the results of each survey with implications for strategy development and recommendations.

11.1 Oral Health Survey – Pre-School Parents (n=299)
In May and June a questionnaire (see Appendix 2) was developed and distributed through Children’s Centres to parents of pre-school children to obtain their views and responses to questions regarding the oral health of their children. 299 responses were received. The sex of the children were - boys – 143, girls – 151, Not stated – 5. The age structure of the responses are as follows –

<table>
<thead>
<tr>
<th>Age band</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>under 1</td>
<td>44</td>
<td>15%</td>
</tr>
<tr>
<td>1 to 2</td>
<td>71</td>
<td>24%</td>
</tr>
<tr>
<td>2 to 3</td>
<td>90</td>
<td>30%</td>
</tr>
<tr>
<td>3 to 4</td>
<td>53</td>
<td>18%</td>
</tr>
<tr>
<td>4 to 5</td>
<td>24</td>
<td>8%</td>
</tr>
<tr>
<td>5+</td>
<td>17</td>
<td>6%</td>
</tr>
<tr>
<td>Total</td>
<td>299</td>
<td>100%</td>
</tr>
</tbody>
</table>

A relatively high percentage of responses come from the most deprived areas within Wakefield. This probably reflects the fact that Children’s Centres are based in the most deprived communities and this was the means by which they were completed. The deprivation structure of the responses were as follows -

<table>
<thead>
<tr>
<th>Deprivation (IMD) Quintile</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>97</td>
<td>32%</td>
</tr>
<tr>
<td>2</td>
<td>64</td>
<td>21%</td>
</tr>
<tr>
<td>3</td>
<td>53</td>
<td>18%</td>
</tr>
<tr>
<td>4</td>
<td>35</td>
<td>12%</td>
</tr>
<tr>
<td>5</td>
<td>29</td>
<td>10%</td>
</tr>
<tr>
<td>Insufficient Postcode</td>
<td>15</td>
<td>5%</td>
</tr>
<tr>
<td>Out of District</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>299</td>
<td>100%</td>
</tr>
</tbody>
</table>
The survey questions were mostly based on guidance in the Department of Health document “Delivering Better Oral Health” (Department of Health, 2009), to compare behaviours in the Wakefield population to nationally recommended standards.

11.1.1 Parental involvement in brushing
Guidance from DBOH – “Children need to be helped or supervised by an adult when brushing until at least 7 years of age”

80% of 1-6 yr olds have supervision from an adult or both child and parent brushes teeth (204 out of 255 – Children under 1 not included in these results).

<table>
<thead>
<tr>
<th>Age</th>
<th>1 year olds</th>
<th>2 year olds</th>
<th>3 year olds</th>
<th>4 year olds</th>
<th>5+ yr olds</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number/Total</td>
<td>58/71</td>
<td>73/90</td>
<td>44/53</td>
<td>19/24</td>
<td>10/17</td>
<td>204/255</td>
</tr>
<tr>
<td>% helped or supervised</td>
<td>81.69%</td>
<td>81.11%</td>
<td>83.02%</td>
<td>79.17%</td>
<td>58.82%</td>
<td>80.00%</td>
</tr>
</tbody>
</table>

11.1.2 Rinsing/Spitting after brushing
Guidance from DBOH – “Rinsing with lots of water after brushing should be discouraged – spitting out excess toothpaste is preferable.”

9.4% (24/255) of parents of 1-6 year olds stated their child rinses with lots of water, 37.7% (96/255) spit out excess toothpaste, 45.1% rinse with a little water (115/255) and 7.8% (20/255) did not answer.

Figure 33 - % of responses to question – “At the end of brushing, what happens?”
11.1.3 Frequency of brushing
Guidance from DBOH – “Brushing should occur twice daily – clean teeth last thing at night before bed and at least one other time each day.”

72.6% (185/255) of parents of 1-6 year olds stated their child “brushed at night and one other time, every day”. This varied slightly by age as shown in figure ?? below -

Figure 34 - % of responses “brushed at night and one other time, every day” by age

68.2% (174/255) of parents of 1-6 year olds stated their “child’s teeth are brushed enough”, 10.6% (44/255) did not think they were brushed enough and 17.3% (27/255) thought they were almost brushed enough.

Of those parents that stated their child brushed their teeth enough, only 85.1% (148/174) actually brushed to the recommended standard. Of those that stated their child did not brush their teeth enough, 14.8% (4/27) actually brushed to the recommended standard. Of those that stated their child “almost” brushed enough, 54.6% (24/44) actually brushed to the recommended standard.
11.1.4 Age teeth brushing started
Guidance from DBOH – “Brushing should start as soon as the first deciduous tooth erupts.”

25.7% (77/299) of all parents stated their child’s teeth were first brushed “when teeth first came through”. When added to those that responded “under 1 year” this increases to 68.9% (206/299) of parents. 22.4% (67/299) of parents stated they started brushing between 1 and 2 years old and 4.0% (12/299) started brushing between 2 and 3 years old.

Figure 36 - % of responses to “How old was your child when they first started having their teeth brushed?”
11.1.5 Bottle and free-flow cup use
Guidance from DBOH – “from age one year feeding from a bottle should be discouraged.”

56.9% (145/255) of parents of children aged 1 or over stated that they “often” or “sometimes” used a bottle or free flow cup. 35.2% (51/145) of these responses stated they went to bed with it. So 20.0% (51/255) of all children aged 1 or over were going to bed with a bottle or free-flow cup.

34.0% (32/94) of parents of children 3 yrs old or more stated they still used a bottle or free-flow cup “often” or “sometimes”.

11.1.6 Types of drinks
Guidance from DBOH – “The frequency and amount of sugary food and drinks should be reduced and, when consumed, limited to mealtimes.”

Parents had the opportunity to select several options for which drinks their child drank most often. 294 parents responded to this question and there were 854 options selected in total which were distributed as follows -

**Figure 37 - % of parents (who answered the question) who selected type of drink child drinks most often**

The drinks with the highest sugar content were not frequently reported by parents. Fruit juice and squash were the highest with 31.0% and 20.7% respectively. It is possible that these results could be influenced by response bias where the respondents give the answers they feel are socially acceptable.
11.1.7 Choosing Toothpaste
Guidance from DBOH – “Children under 3 years should use a toothpaste containing no less than 1,000 ppm fluoride….Family fluoride toothpaste (1,350–1,500 ppm fluoride) is indicated for maximum caries control for all children.”

Parents were asked “What is important to you when choosing which toothpaste to buy your child?” Parents could select several options (similar to the question on drinks consumed). 284 parents responded to this question and 431 options were selected in total which were distributed as follows –

Figure 38 - % of parents (who answered the question) who selected factor that is important when choosing toothpaste

[Bar chart showing the distribution of reasons for choosing toothpaste]

Age related factors are by far the most common reason with two-thirds of parents stating this as a reason why they choose certain toothpaste for their children. Only a third of parents consider fluoride content. 1 in 6 parents consider either make/brand or taste/flavour when choosing toothpaste. 1 in 9 parents consider cost when choosing toothpaste. As with the responses to drinks consumed, this question is open to response bias where parents might give answers they feel are socially acceptable.

11.1.8 Local Healthy Teeth programmes in Children’s Centres
Parents were asked “Does your local children’s centre run healthy teeth programmes?” Over half of parents (55.9% - 167/299) didn't know, only a third were aware (35.8% - 107/299) and 5.7% (17/299) said no. Of those parents who were aware that their children’s centre did run a programme, only 43.0% (46/107) had children who participated in them.

11.1.9 Visiting the dentist
Parents were asked “When was your child’s last visit to the dentist?” 45.2% (135/299) stated in the last 6 months, 38.5% (115/299) stated they had never been to the dentist and 11.0% (33/299) stated 6-12 months ago.
The following graph illustrates the percentage of each age group who were reported to have never have visited the dentist.

There is a declining trend of those that have not visited the dentist in each increasing age group. More than 1 in 10 children aged 5 or over had never visited the dentist (although this group were small in number in the survey - 2 out of 17).
When parents were asked if it is difficult to get their child routine dental care, 9.4% (28/299) answered ‘yes’. 67.6% (202/299) said ‘no’ and the rest either did not answer or stated they didn’t know.

Of the 28 parents that indicated it was difficult, the following graph demonstrates the reasons given (some parents gave multiple reasons) –

**Figure 41 - Count of reasons given by parents for difficulty in accessing routine dental care**

![Graph showing reasons for difficulty in accessing routine dental care](image)

3 out of the 5 responses in the ‘Other’ category stated that it was hard to make appointments.

Parents were also asked if they had difficulties getting their child dental care if they were having difficulties. 5.7% (17/299) responded ‘yes’ and 58.2% (174/299) stated ‘no’. The rest either stated ‘don’t know’ or did not answer the question.

Of the 17 parents who indicated it was difficult, the following graph demonstrates the reasons given (some parents selected multiple reasons) –
11.1.10 Treatment child received at the dentist

Parents were asked “What treatment has your child ever received from a dentist?” 185 parents answered this question and could select a number of responses. The 251 options selected by parents were distributed as follows –

Figure 43 - % of parents (who answered the question) who selected each treatment ever received from a dentist
The vast majority of parents stated that their child had received a ‘check-up’. Only 1 in 5 parents reported receiving ‘advice on looking after teeth’ from the dentist. Nearly 1 in 10 parents reported their child having fillings or teeth removed by a dentist.

### 11.1.11 Following advice from dentists

Parents were asked to indicate how likely they are to follow advice given by a dentist, using a Likert scale between 1 and 5 (“please circle 1 2 3 4 5” where 1 is “not likely” and 5 is “very likely”).

88.0% (263/299) of parents stated that they were likely (4 or 5 on the scale) to follow advice given by a dentist. This highlights the importance of dentists giving prevention messages to parents of pre-school children and the likelihood that they might respond.

### 11.1.12 Responses by Deprivation

It is possible to analyse all the responses from parents by deprivation, using the postcode provided, to identify if families living in more deprived parts of the district responded differently to their more affluent neighbours. IMD was used for deprivation scores and these were split into five categories of comparative deprivation (quintiles) across the district. The following table demonstrates the percentage of responses in each quintile for the most relevant answer to the questions asked in the survey –

<table>
<thead>
<tr>
<th>IMD Quintiles</th>
<th>Help brushing? (2or4)</th>
<th>Frequency (1)</th>
<th>Enough? (1)</th>
<th>Age 1st brushed (1or5)</th>
<th>Bottle use (1or2)</th>
<th>Dentist visit last 6 mths (1)</th>
<th>Dentist visit never (5)</th>
<th>Accessing routine dental care difficult (1)</th>
<th>Accessing dental care when problems (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>83.52%</td>
<td>70.3%</td>
<td>68.1%</td>
<td>61.86%</td>
<td>46.15%</td>
<td>54.6%</td>
<td>26.8%</td>
<td>8.25%</td>
<td>7.22%</td>
</tr>
<tr>
<td>2</td>
<td>72.22%</td>
<td>68.5%</td>
<td>72.2%</td>
<td>60.94%</td>
<td>64.81%</td>
<td>31.3%</td>
<td>57.8%</td>
<td>14.06%</td>
<td>4.69%</td>
</tr>
<tr>
<td>3</td>
<td>87.23%</td>
<td>78.7%</td>
<td>66.0%</td>
<td>79.25%</td>
<td>51.06%</td>
<td>49.1%</td>
<td>37.7%</td>
<td>11.32%</td>
<td>3.77%</td>
</tr>
<tr>
<td>4</td>
<td>75.00%</td>
<td>85.7%</td>
<td>82.1%</td>
<td>91.43%</td>
<td>57.14%</td>
<td>51.4%</td>
<td>40.0%</td>
<td>8.57%</td>
<td>8.57%</td>
</tr>
<tr>
<td>5</td>
<td>78.95%</td>
<td>68.4%</td>
<td>57.9%</td>
<td>72.41%</td>
<td>78.95%</td>
<td>31.0%</td>
<td>37.9%</td>
<td>6.90%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Some of these percentages hide some small number effects where the denominator is quite small so is less reliable. However, there is no clear evidence in these figures that indicates that those in most deprived areas of the district answered the questions in a way that indicates disadvantage in optimising oral health.
11.2 Oral health Survey – Mental Health
Along with the local survey of pre-school parents, a survey was undertaken of people in contact with mental health secondary services. 104 responses were given. As a significant number of responses were collected in the community memory clinic (which serves a mainly older population), there is an over-representation of older people in the sample. Responses from people over 60 years old numbered 76 out of a total of 104 (73%). As such this survey is not representative of the population in Wakefield in contact with secondary mental health services. Despite this caveat, the results from this survey will be described below.

11.2.1 Importance of Oral Health
Respondents were asked how important they considered oral health to be in a general sense. A Likert scale (from 1 to 5 – not important to very important) was used and respondents were asked to circle their answer. The vast majority of respondents indicated that oral health was important to them with 84 out of 104 (80.8%) scoring it as a four or five on the scale. The following number of respondents answered the question –

Figure 44 - Number of respondents indicating how important oral health is to them

11.2.2 Frequency of Tooth Brushing
The mental health service users were asked to indicate the frequency with which they brushed their teeth. Only half brushed their teeth at least twice a day (51%). A small number reported never brushing their teeth but most of these responses indicated that they had dentures and this was the reason. The following graph indicated the percentage of respondents for each response –

---

70
11.2.3 Last Visit to the dentist
Over half of MH respondents had visited the dentist in the last year (58.7%). Over 10% had not been in the last 5 years.

11.2.4 Difficulty accessing routine dental care
Over two-thirds of MH respondents stated they did not have any problems accessing routine dental care. For 6.7% of respondents it was a problem.
Of the responses who stated they had problems, the following table indicates the reasons they gave (some respondents indicated ‘no’ but gave an answer here) –

**Reasons for difficulty accessing routine care**

- Scared of dentists/treatment: 3
- No information on local dentists: 0
- Lack of time/inconvenient opening hours: 1
- No dentists taking patients: 1
- Difficult to make the journey to the dentist: 2
- Dentists only treating privately: 2
- Treatment too expensive: 1
- Don’t know: 0
- Other (please give details): 2

### 11.2.5 Difficulty accessing urgent dental care

Nearly three-quarters of MH respondents stated they did not have problems accessing urgent dental care if they were having problems. A small number of respondents did have problems accessing urgent dental care (2.9%).
Of those who indicated they had difficulty accessing urgent care, the following table indicates the reasons they gave (some respondents indicated ‘no’ but gave an answer here) -

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scared of dentists/treatment</td>
<td>3</td>
</tr>
<tr>
<td>No information on local dentists</td>
<td>1</td>
</tr>
<tr>
<td>Lack of time/inconvenient opening hours</td>
<td>0</td>
</tr>
<tr>
<td>No dentists taking patients</td>
<td>0</td>
</tr>
<tr>
<td>Difficult to make the journey to the dentist</td>
<td>1</td>
</tr>
<tr>
<td>Dentists only treating privately</td>
<td>0</td>
</tr>
<tr>
<td>Treatment too expensive</td>
<td>1</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
</tr>
<tr>
<td>Other (please give details)</td>
<td>2</td>
</tr>
</tbody>
</table>

11.2.6 Following advice from dentists
The survey asked respondents to indicate how much they would follow advice from a dentist on a Likert scale between 1 (Do not follow advice at all) and 5 (completely follow advice). Half of the MH respondents indicated they were likely to follow dental advice (circled 4 or 5). One in ten respondents indicated they would not follow advice from dentists (10.6% circled 1 or 2).
11.3 Oral Health Survey – Older People
Along with the local survey of pre-school parents and mental health service users, a survey was undertaken of older adults (over 50 years old). This was undertaken through some community pharmacies and through Age UK community service. Responses were received from 132 individuals, however only 74 of these were over 50 and so it was this sub group that is analysed below. Given the small sample size, we cannot be confident that this survey is representative of all people in Wakefield over 50 and so firm conclusions from this survey cannot be made. Despite this caveat, the results from this survey will be described below.

11.3.1 Importance of oral health
Respondents were asked how important they considered oral health to be in a general sense. A Likert scale (from 1 to 5 – not important to very important) was used and respondents were asked to circle their answer. The vast majority of respondents indicated that oral health was important to them with 60 out of 74 (81.1%) scoring it as a four or five on the scale. The following number of respondents answered the question –
11.3.2 Tooth Brushing Frequency
The older adults were asked to indicate the frequency with which they brushed their teeth. Nearly two-thirds brushed their teeth at least twice a day (64%). A small number reported never brushing their teeth but most of these responses indicated that they had dentures and this was the reason. The following graph indicated the percentage of respondents for each response –

Figure 51 - Percentage of OA respondents indicating the frequency they brushed their teeth
11.3.3 Visiting the dentist
Over 80% of older adults reported their last visit to the dentist was within the last two years. All respondents (n=74) had been to the dentist in the last 5 years.

Figure 52 - Percentage of OA respondents reporting their last visit to the dentist

11.3.4 Problems accessing routine dental care
Nearly 10% of respondents reported having problems accessing routine dental care. The vast majority (78.4%) stated they had no difficulties. Around 12% of respondents didn't know or didn't answer.

Figure 53 - Percentage of OA respondents stating any difficulties accessing routine dental care
For those that stated difficulty in accessing routine dental care, these are the reasons they gave –

**Reasons for difficulty accessing routine care**

- Scared of dentists/treatment: 2
- No information on local dentists: 1
- Lack of time/inconvenient opening hours: 1
- No dentists taking patients: 1
- Difficult to make the journey to the dentist: 1
- Dentists only treating privately: 1
- Treatment too expensive: 2

**11.3.5 Accessing urgent dental care**

Most respondents did not report having problems accessing urgent dental care when they had problems (81.1%). 1 in 20 respondents stated they had problems but these were only 4 people so conclusions cannot be drawn on the significance of this number.

**Figure 54 - Percentage of OA respondents indicating if they had difficulty accessing urgent dental care when they were having problems**

![Figure 54](image)

**11.3.6 Following advice from a dentist**

The survey asked respondents to indicate how much they would follow advice from a dentist on a Likert scale between 1 (Do not follow advice at all) and 5 (completely follow advice). Around 70% of the OA respondents indicated they were likely to follow dental advice (circled 4 or 5). One in fourteen respondents indicated they would not follow advice from dentists (6.8% circled 1 or 2).
11.4 Oral Health Survey – Care Home Managers
A local survey was undertaken with managers of residential care establishments across the district. This was mainly to understand the arrangements for dental care in these establishments and what particular oral health needs were evident in these settings.

Seventy three surveys were sent out to a list compiled from a Local Authority list and the CQC website of registered care and nursing homes. Thirty three responses were received. Not all residents of these registered homes will be previous residents of Wakefield district but it is assumed most would be and that the implications on dental services would be felt amongst Wakefield services. In 2015 it is anticipated that NICE will produce oral health guidelines for care and nursing homes.

11.4.1 Types of Establishments
Of the 33 responses to the survey, 28 establishments described themselves as a residential home (with nursing not available) and 5 described themselves as a nursing home (with nursing available). The 5 nursing homes were all the largest establishments (with the highest bed capacity). These ranged from 50 beds to 172 beds. The residential homes’ capacity ranged from 3 beds to 47 beds. The average bed capacity across the 33 establishments was 30.

Of the 33 establishments that responded, 27 were privately run establishments, 4 were local authority run and 2 did not answer. The average bed occupancy was 92%, with 15 of the establishments reporting 100% bed occupancy. (The average is affected by one newly opened establishment with a low bed occupancy of 24%.)
The member of staff completing the survey was almost always a senior member of staff. Of the 33 responses, 26 identified themselves as home managers, 5 were deputy managers, 1 was a nurse in charge and 1 was a care/nursing assistant.

11.4.2 Oral Health ‘Champion’
The Scottish NHS programme ‘Caring for Smiles’ (2013) encourages residential homes to appoint an oral health ‘champion’.

Care homes were asked if they had an oral health champion. 30 stated they did not, 1 stated it did and 2 did not answer. The home that stated they did have a champion, indicated that the staff member was a manager and a care/nursing assistant.

11.4.3 Oral Health Training Sessions
Care homes were asked if any oral health training sessions had been provided for their staff (internally or externally delivered). Of the 33 responses, 18 stated they did have, 13 stated they had not, 1 did not know and 1 did not answer.

The following figure indicates how recently the training had taken place for staff.

Figure 56 - Number of responses to the question ‘When was the last oral health training session delivered?’

11.4.4 Accessing Routine Dental Care
Care homes were asked if their residents accessed routine dental care on a regular basis (check-ups etc) and if so how that was undertaken.

Of the 33 responses, 27 indicated their residents did access routine care regularly and 6 indicated that they didn’t.
The following graph indicates the responses explaining how residents accessed dental care.

**Figure 57 - Number of responses outlining how residents of care homes accessed routine dental care**

11.4.5 Accessing Urgent Dental Care

Care homes were asked how often they needed to arrange dental care for urgent/emergency problems for any of their residents. Most homes had to arrange this at least once a year (23/33).

**Figure 58 - Number of responses from care homes indicating how often they had to arrange urgent/emergency dental care for any of their residents**

The following graph indicates how care homes stated they arranged for this urgent/emergency care to take place.
Figure 59 - Number of responses indicating how care homes stated they arranged urgent/emergency dental care

The responses for routine and urgent dental care indicate a possible lack of NHS dentistry services in-reaching to care home residents as most care homes had to arrange private dentist provision to attend the home or escorted patients to a dentist. This is a potential gap in service and represents an inequality in provision of dental services to this vulnerable group.

11.4.6 Transport issues with accessing dental services

The survey asked to what extent the care home manager thought transport was an issue in accessing dental services. Over half (18/33) felt it was an issue ‘often’ or ‘sometimes’. A third (10/33) stated it was never an issue. The survey offered the opportunity to comment and the ‘never’ responses corresponded with homes having their own transport available and for use in these cases where dental care was required. Transport does seem to be an issue for some homes and may present a barrier to accessing care. The figure below summarises the responses.
11.4.7 Oral Health Assessment on Admission
The survey asked respondents whether an oral health risk assessment was carried out on admission to the home. Less than a third stated they undertook an assessment on admission (10/33). Of the 10 that stated they did undertake an assessment, 7 of them undertook this assessment within 48 hours of admission. All 10 respondents stated that the home undertook the assessment within the first 5 days of admission.

Figure 61 - Number of respondents stating when the oral health risk assessment was undertaken after admission to the home
11.4.8 Tooth brushing
The survey asked respondents to state the frequency of tooth brushing for most of their residents. Nearly two-thirds of respondents (19/33) stated the frequency was once at night as well as once at another time in the day. This is the recommended standard. Just over a third of responses (13/33) stated the frequency was once a day (either at night or in the daytime). This brushing frequency does not meet recommended national standards.

Respondents to the survey stated how often a record was kept of tooth brushing for each resident. Less than a third of respondents (9/33) stated it was recorded ‘always’ or ‘often’. Over a third responded that it never happened (13/33). The graph below illustrates these responses.

**Figure 62 - Care Home responses to the question ‘Does your care home keep a record of frequency of tooth brushing of each resident?’**

This data indicates a significant minority of care home residents are not having their teeth brushed to the recommended standards and the majority of care homes are not recording if it has taken place or not.

11.4.9 Dentures
The survey asked respondents how many of their residents wore dentures. Nearly half did not answer the question (16/33). Of those that did answer the question, on average 60% of residents wore dentures (ranged from 6% to 95%).

Respondents were asked how often the dentures were cleaned. The frequency was less than for tooth brushing overall. Just over a third (12/33) of respondents stated their residents’ dentures were cleaned twice a day (recommended tooth brushing frequency). Nearly half (16/33) of respondents stated that their residents’ dentures were cleaned once a day.
When asked how often their residents’ dentures were soaked at night, the majority (24/33) of respondents stated they were soaked on a daily basis. A small number (3/33) stated their residents’ dentures were soaked at least twice weekly. Six respondents did not answer the question.

11.4.10 Key Issue to Address
The survey asked respondents if there was one single issue that they felt would make the biggest difference to the oral health of their residents. Just over a third of respondents (12/33) did not answer the question. Of the remaining 21 respondents who did, 10 stated that having improved access to dentists in the form of them visiting the home was the most significant change. Six stated that improved awareness and education for staff and/or residents was the most significant change.

Other comments included ‘dementia friendly toothbrushes’, ‘dentures supplied with the residents names or initials on them’, ‘all our residents are all mobile and look after their own teeth’ and ‘we need to do oral health assessment on admission and designate a senior member of staff to oversee this’.

11.5 Wakefield Community Dental Service – Patient Experience
During 2013/14, Wakefield Community Dental Service completed three audits, where patient satisfaction was assessed: paediatric and adults with special needs general anaesthesia services and community clinics.

There is extremely positive feedback from on-going questionnaires received from the carers/parents of the special needs GA adult and child patients. The key findings were:

- Respondents reported that care provided was excellent, that they felt they were treated with respect and dignity and in a friendly but professional atmosphere, with staff taking time to understand the patients' special needs;
- With regards to the children’s extraction GA list, 96% of parents/carers found the experience and service offered in clinic and at the hospital excellent or good;
- Nearly all respondents reported that they treated with dignity and respect (97%); and
- That they benefitted from the preventive advice provided by the oral health promotion team (98%).

Working in partnership with the Learning Disability Team has assisted in improving patient experience.

With regards to the general community dental service clinics the key findings were:

- Patients reported being very satisfied with all aspects of the service;
- Patients were happy with the professionalism of the team; and
- All patients said that the dentist and nurse put them at ease and felt that treatment was explained in clearly.
11.6 Dental Phobic Support Group – Gentle Steps

In 2013 a member of the community in Wakefield, identified additional needs for people in the district with dental phobia through community development work undertaken on a voluntary basis. She identified that people with dental phobia would benefit from extra support and information locally to assist them in accessing necessary dental care. The community support group “Gentle Steps” was therefore established. Over the first year 5 meetings have taken place and contact and support provided to between 20 and 30 individuals in the district. Joint working between the group and the community dental service has begun, with opportunities being explored where patients can be sign posted between both.

This support group is a community asset within the district which benefits the oral health of people within the district and with continued support from statutory agencies, can make a significant difference to an unknown but potentially large group of people with dental phobia.
12. References


Department of Health (2010b). Equity and excellence: Liberating the NHS. London: HMSO.


### Appendices

#### Appendix 1
Data from National Oral Health Surveys

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<tr>
<th>Age</th>
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<th>Population</th>
<th>% with DMFT&gt;0</th>
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<th>Upper 95% CI</th>
<th>Mean DMFT</th>
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<td>37.7%</td>
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Appendix 2

Wakefield Oral Health Questionnaire 2014 (Pre-School Parent Questionnaire)

Q1. What is the sex of your child? (Please tick) □ Male □ Female

Q2. How old is your child (in years and months)? ________________ Years ________________ Months

Q3. What is their postcode? ___________ E.g. W1F 1E2

Q4. Who brushes your child’s teeth? (Please tick)

□ Child □ Child with supervision □ Parent/guardian □ Both parent/guardian and child

Q5. At the end of brushing, what happens? (Tick all that apply)

□ Spitting out excess toothpaste □ Rinsing with a little water □ Rinsing with a lot of water

Q6. In terms of how often your child’s teeth are brushed, which of the following statements is the best description?

□ Brushed at night and one other time, every day □ Brushed once at night only, every day

□ Brushed once during the day, every day □ Brushed at least once on some days

□ Brushed rarely □ Never brushed

Q7. Do you think your child’s teeth are brushed enough?

□ Yes □ No □ Almost □ Don’t Know

Q8. How old was your child when they first started having their teeth brushed?

□ Under 1 year □ 1 – 2 years □ 2 – 3 years □ 3 years or over

□ When teeth first came through □ Can’t remember □ Teeth are not cleaned

Q9. When was your child’s last visit to the dentist?

□ Last 6 months □ 6 – 12 months □ 1 – 2 years □ Over 2 years □ Never visited dentist

Q10. What treatment has your child ever received from a dentist? (Please tick all that apply)

□ Check-up □ Advice on looking after teeth □ Fluoride varnish □ Fillings □ Teeth removed
Q11. Is it difficult for you to get your child **routine** dental care (e.g. check-ups and fillings)? (Please tick one)

- Yes  (Go to Q12.)  
- No    (Go to Q13.)  
- Don't Know/Can’t remember  (Go to Q13.)

Q12. If you answered yes to Q11, what makes it difficult? (Please tick all that apply)

- Scared of dentists/treatment
- No information on local dentists
- Lack of time/inconvenient opening hours
- No dentists taking patients
- Difficult to make the journey to the dentist
- Dentists only treating privately
- Dentist not child friendly
- Don't know
- Other (please give details) -

Q13. Is it difficult for you to get your child dental care if they are having problems? (Please tick one)

- Yes   (Go to Q14.)  
- No    (Go to Q15.)  
- Don't Know  (Go to Q15.)

Q14. If you answered yes to Q13, what makes it difficult? (Please tick all that apply)

- Scared of dentists/treatment
- No information on local dentists
- Lack of time/inconvenient opening hours
- No dentists taking patients
- Difficult to make the journey to the dentist
- Dentists only treating privately
- Dentist not child friendly
- Don't know
- Other (please give details) -

Q15. If a dentist gives you advice for your child, how likely are you to follow it? (Please circle a number)

(Not Likely)  1  2  3  4  5  (Very Likely)

Q16. Does your child use a bottle or free flow cup?

- Often  (Go to Q17)  
- Sometimes  (Go to Q17)  
- Never  (Go to Q18.)

Q17. If they do use a bottle or free flow cup, do they go to bed with it?  

- No  
- Yes
Q18. Thinking of the drinks that you give your child, which do they drink most often? (Please put a number to indicate most often: 1=most often, 2=second most often, 3=third most often)

☐ Cow’s Milk  ☐ Breast milk  ☐ Other milk  ☐ Fruit juice  ☐ Water
☐ Fizzy drinks  ☐ Sugar-free fizzy drinks  ☐ Squash  ☐ Sugar-free squash  ☐ Energy
☐ Tea  ☐ Coffee  ☐ Hot Chocolate  ☐ Other

Q19. What is important to you when choosing which toothpaste to buy your child? (please tick all that apply)

☐ Make/brand  ☐ Cost  ☐ Taste/Flavour  ☐ Ads  ☐ Age related
☐ Fluoride content  ☐ Number of stripes  ☐ Other reason

Q20. Does your local children’s centre run healthy teeth programmes?

☐ Yes  ☐ No  ☐ Don’t Know

Q21. If yes to Q20, has your child participated in these?

☐ Yes  ☐ No  ☐ Don’t Know

Thank you for taking the time to answer these questions!