

FINAL DRAFT

Leeds Oral Health Strategy

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Leeds Oral Health Strategy

1 INTRODUCTION

1.1 BACKGROUND

Having good oral health is an integral part of healthy living and makes an important contribution to an attractive appearance, self-esteem and quality of life. Good oral health enables people to eat and enjoy a variety of foods and to communicate effectively. Poor oral health, on the other hand, often results in pain, discomfort, sleepless nights, time off work or school and limitations in eating function leading to poor nutrition.

.Although there have been improvements in dental health, tooth decay still causes much pain and suffering. Nationally 14% of children already have decayed teeth by 2½ - 3½ years of age. In Leeds 55% of 5 year olds have tooth decay, and by the age of 14 years 65% have experienced decay in some of their adult teeth.

In adulthood gum disease becomes of greater concern and, together with tooth decay, results in nearly 60% of Leeds residents aged over 65 years having none of their own natural teeth (Beal and Prendergast, 1992). This devastation, however, is unnecessary as both tooth decay and gum disease are largely preventable.

Whilst affecting comparatively few people, there appears to be an increase in the incidence of oral cancer. Each year about 50 people in Leeds are diagnosed as having oral cancer. Adopting a healthy lifestyle can reduce the risk of the disease and its early detection can improve the chances of full recovery.

Despite the widespread problems caused by dental and oral disease, only 64% of children and 51% of adults in Leeds are registered with a dentist. Registration levels are particularly low among very young children and older adults.

The situation is not, however, uniform across the city. It is those in the most deprived areas which have more tooth decay, and more severe gum disease, that are more likely to lose all their teeth and are at greater risk from oral cancer. They also make the least use of dental services. Other groups have special needs with regard to oral health, including members of some minority ethnic communities, those with physical disabilities, learning difficulties or certain medical conditions. Children and older people also have special needs.

1.2 WHAT IS THIS STRATEGY FOR?

The emphasis of an oral health strategy for Leeds is the prevention of disease and the maintenance of oral health. Clearly the Primary Care Trusts and the dental team have a major role in implementing action aimed at improving the oral health of the local community. Many other organisations and individuals can make important contributions and need to be fully involved in agreeing the programme of action. Central to the strategy, however, are the people of Leeds, for it is their mouths and their teeth which are at stake. Although it will not be easy, ways must be explored to find out what the people want, especially those who are most at risk from poor oral health and who are least likely to overcome the barriers to receiving dental care.

1.3 WHAT DO WE WANT TO ACHIEVE?

The answer to this question will depend on who is asked. Most people want a dentition which is functional for the whole of their life, free of pain and socially acceptable. This means preventing disease which can be prevented and treating that which does occur in a way which enables the person to achieve the above objective.

The Department of Health in the Oral Health Strategy for England (1994) defined oral health as “*a standard of health of the oral and related tissues which enables an individual to eat, speak and socialise without active disease, discomfort or embarrassment and which contributes to general well-being*”. There is a need for the efficient use and equitable distribution of the resources available in Leeds in order to meet that aim. The recent changes to the dental contract and the increasing responsibility for commissioning dental services at a PCT level give the opportunity to start to make a real difference to oral health in Leeds. This strategy has two main components to commissioning services for oral health, these are:–

- Oral health promotion
- Oral health care

SECTION 1 - ORAL HEALTH PROMOTION

1. DISEASES AND CONDITIONS

1.1 DENTAL CARIES

1.1.1 What Is The Current Position?

Dental caries, or tooth decay, is the main disease which affects teeth. The major cause is the consumption of sugars. These are converted into acid by the bacteria in plaque on the surface of the teeth. The acid dissolves the substance of the tooth and as it progresses can result in pain, infection and abscess formation. It may lead to the loss of the tooth, often involving the use of general anaesthesia especially in children. The frequency of sugar consumption is more significant than the amount consumed.

Tooth decay is usually measured in a community in two ways. Firstly, the percentage of the relevant population who have experienced decay, which may remain untreated or may have been treated by filling or extracting the tooth. Second, by measuring the extent to which individuals are affected as indicated by the number of teeth which are currently decayed plus those in which there is a filling and those that are missing following extraction. This is known as the decayed, missing and filled teeth index (dmft for primary or baby teeth and DMFT for permanent or second teeth). The mean (average) is used to express the extent of tooth decay in a population.

Table 1: National and local targets for children's dental health

Age	Oral health indicator	England 1993	England target 2003	England 2003	Leeds 1993	Leeds Target 2003	Leeds 2003
5	with decay experience	43%	30%	39%	53%	40%	55%
5	average decay experience (mean dmft)	1.6	1.0	1.5	2.4	1.6	2.5
12	average decay experience (mean DMFT)	1.2	1.0	1.0	1.4	1.0	1.4
5	difference in mean dmft between children from least and most deprived areas	N/A	None	N/A	2.0	1.3	to add
5	difference in mean dmft between African-Caribbean and Asian children	N/A	None	N/A	2.8	2.0	2.6

The last oral health strategy for Leeds was published in 1997. Table 1 shows the national targets for dental health in children for the year 2003 together with the targets

set out in the Leeds strategy. Also shown is the level of dental health actually achieved both nationally and locally it can be seen that in 5-year-old children neither the targets for England nor those for Leeds was achieved. At the time the last Leeds strategy was produced there was an expectation that the fluoridation of the water supply might be implemented in time for the target to be achieved. It was recognised that without this measure, and in spite of the increasing programme of oral health promotion activity in the city, it was going to be impossible to achieve the target.

Figure 1 shows the percentage of 5-year-old children with decay experience since 1973 for England when the first national survey was undertaken, and since 1985 for Leeds when the current epidemiological survey programme was started. It can be seen that since the reduction in the proportion of children who have tooth decay in the 1970s and early 1980s following the introduction of fluoride toothpaste, there has been little further improvement. Indeed, there is some evidence that the trend may have been reversed and that dental disease is now increasing in young children.

Figure 1 Percentage of 5-year-old children with decay experience 1973-2003 and target for 2003 (England solid black line, Leeds dashed).

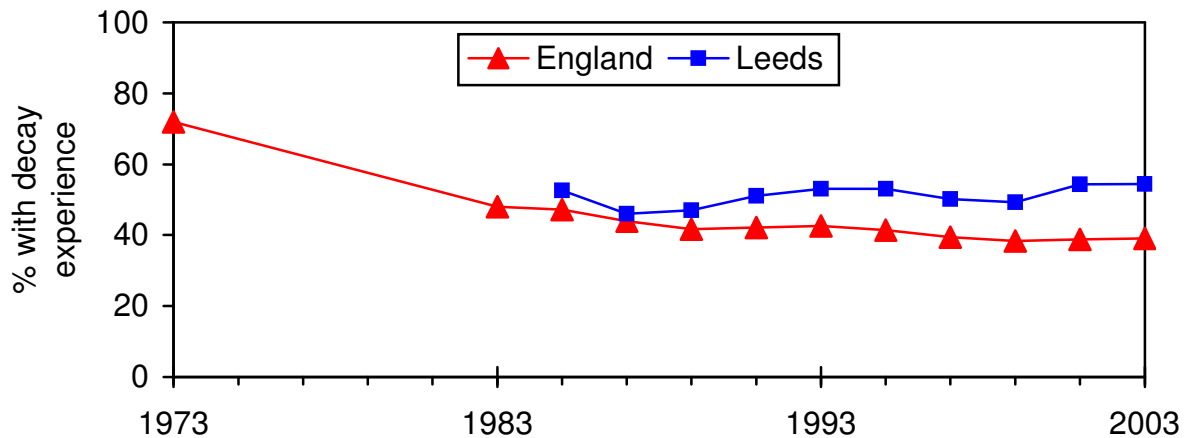
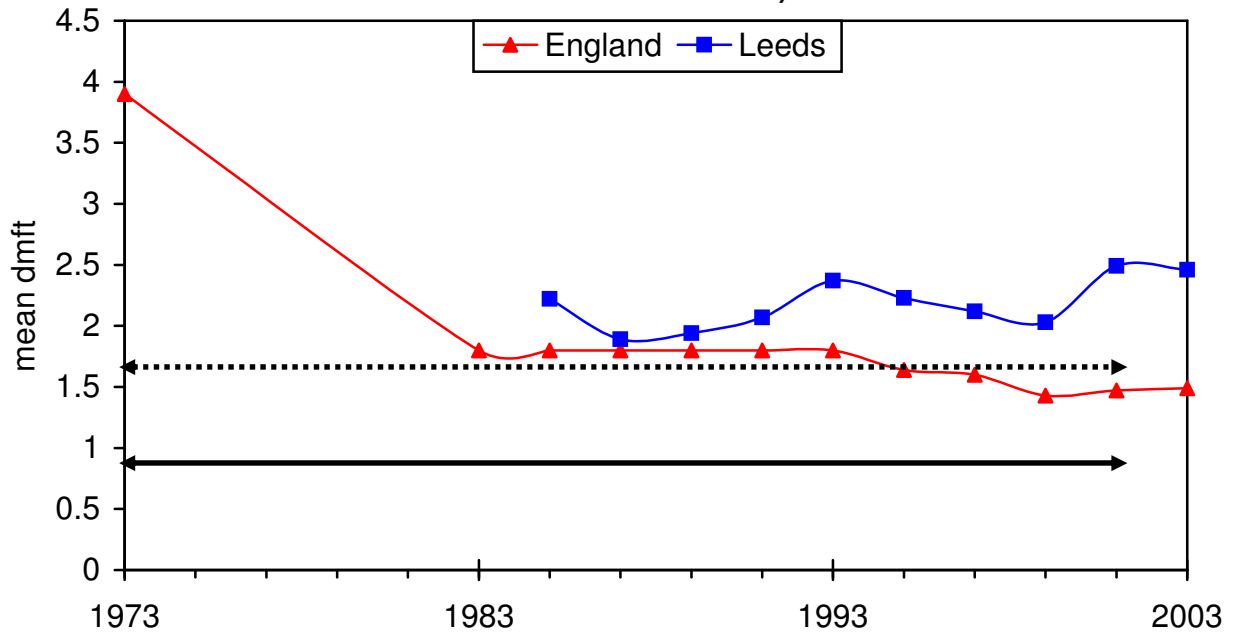


Figure 2 shows the data for the extent of the tooth decay as measured by the number of affected teeth. This follows a similar trend to the proportion of children with decay experience.

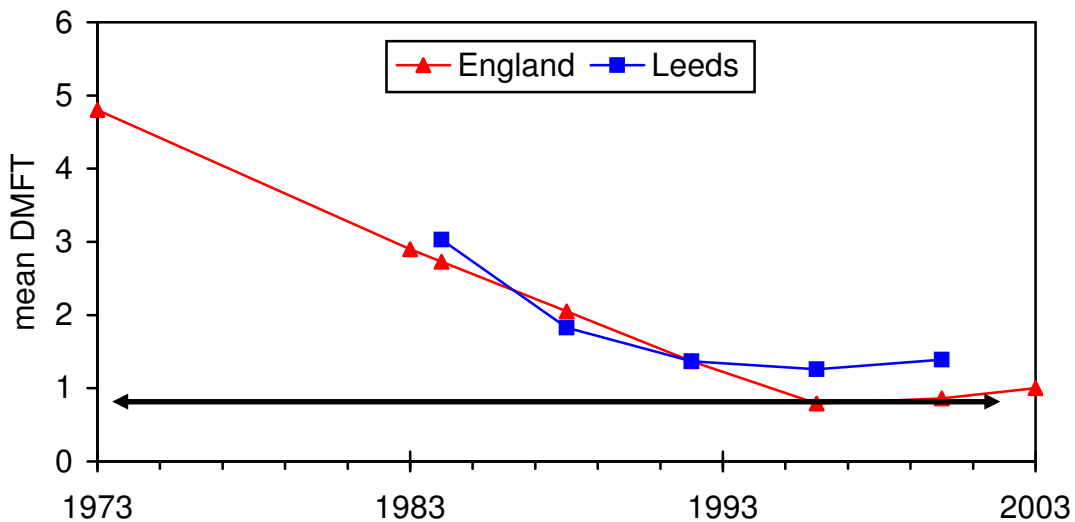
Figure 3 presents the number of decayed, missing and filled permanent teeth in 12-year-old children. The reduction in tooth decay took longer to achieve in this older group. Until the early 1990s Leeds has a similar DMFT to the England average. However, the improvement in Leeds seemed to taper off earlier and the dental health of children in the city is now worse than that in the country as a whole. The situation will need to be monitored in case decay in the permanent teeth follows the trend seen in the primary dentition.

Figure 2: Average number of decayed, missing or filled primary teeth (dmft) in 5 year old children 1973-1994 and targets for 2003 (England solid black line Leeds dashed)

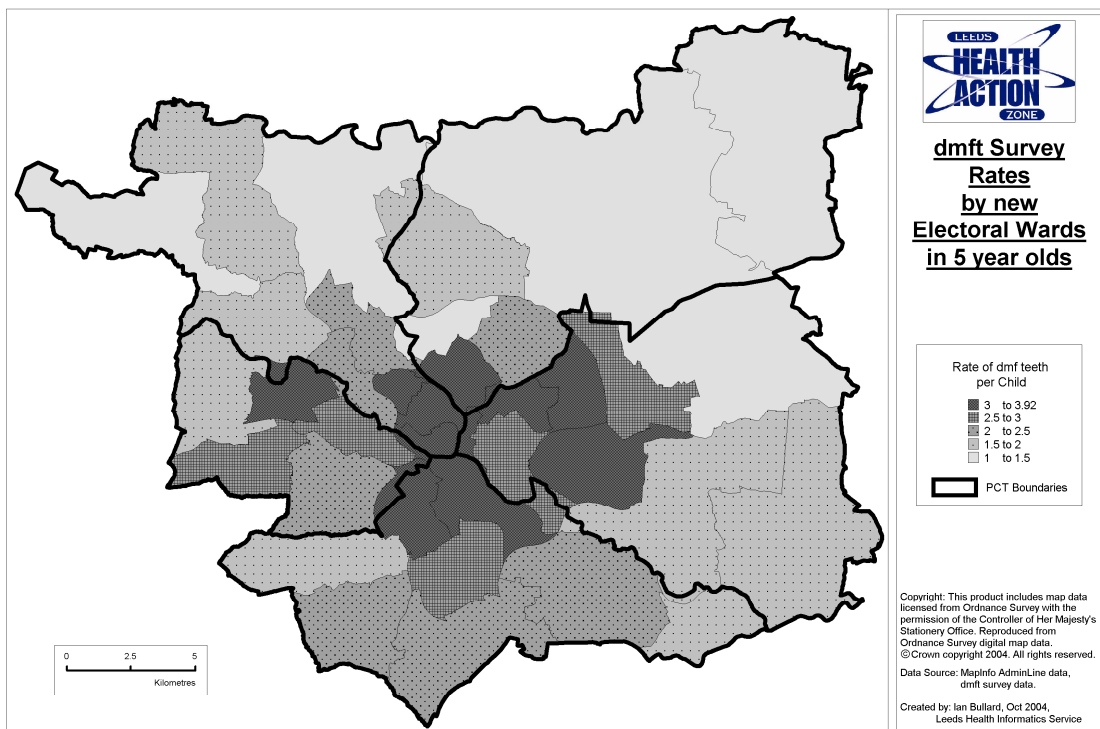


There is a strong association between caries prevalence and socio-economic status. Studies in Leeds and elsewhere have shown that children living in the most deprived areas have nearly three times as much decay as those living in the least deprived areas (Beal & Prendergast, 1995). Map 1 shows the mean dmft of 5-year-olds in each ward in Leeds, with the wards where the children have the most tooth decay shown in the darker shades and those with the least tooth decay in the lighter shading. Map 2 shows the Index of Multiple Deprivation where red indicates the most deprived areas and green the most affluent areas. The association between deprivation and high levels of tooth decay can clearly be seen.

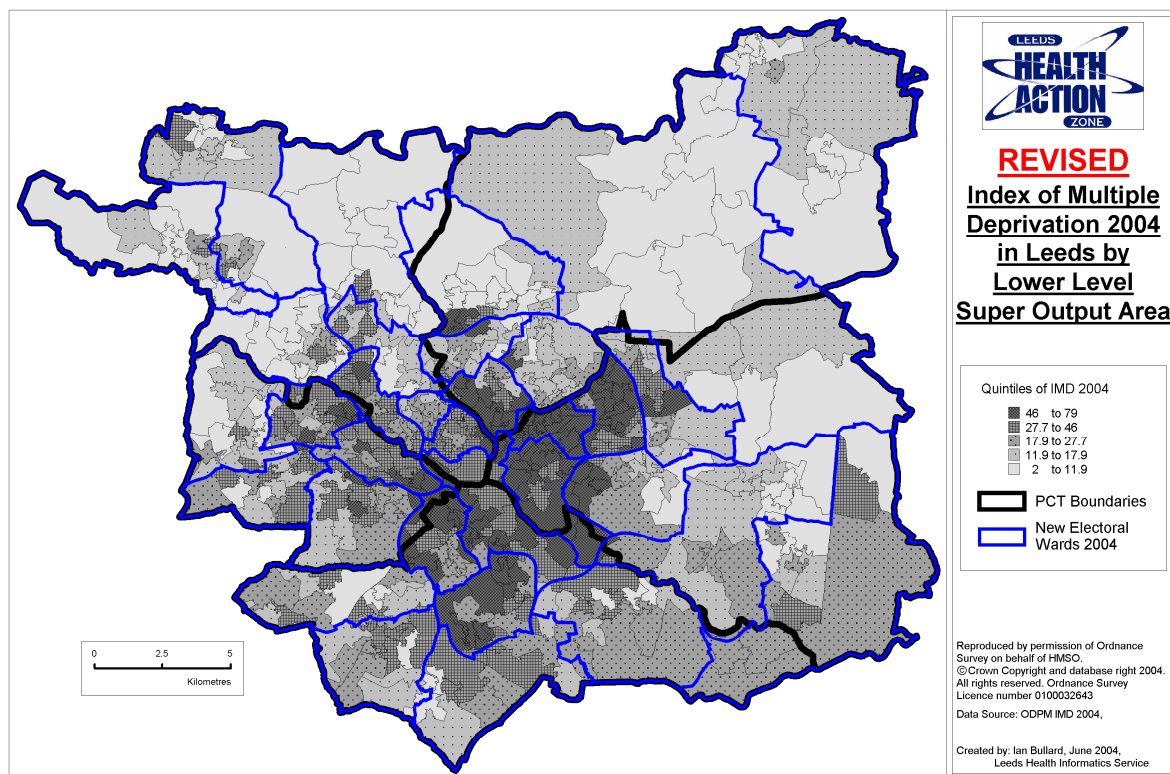
Figure 3: Average number of decayed, missing or filled permanent teeth (DMFT) in 12 year old children 1973-2003 and targets for 2003 (England and Leeds same target - solid black line)



MAP 1



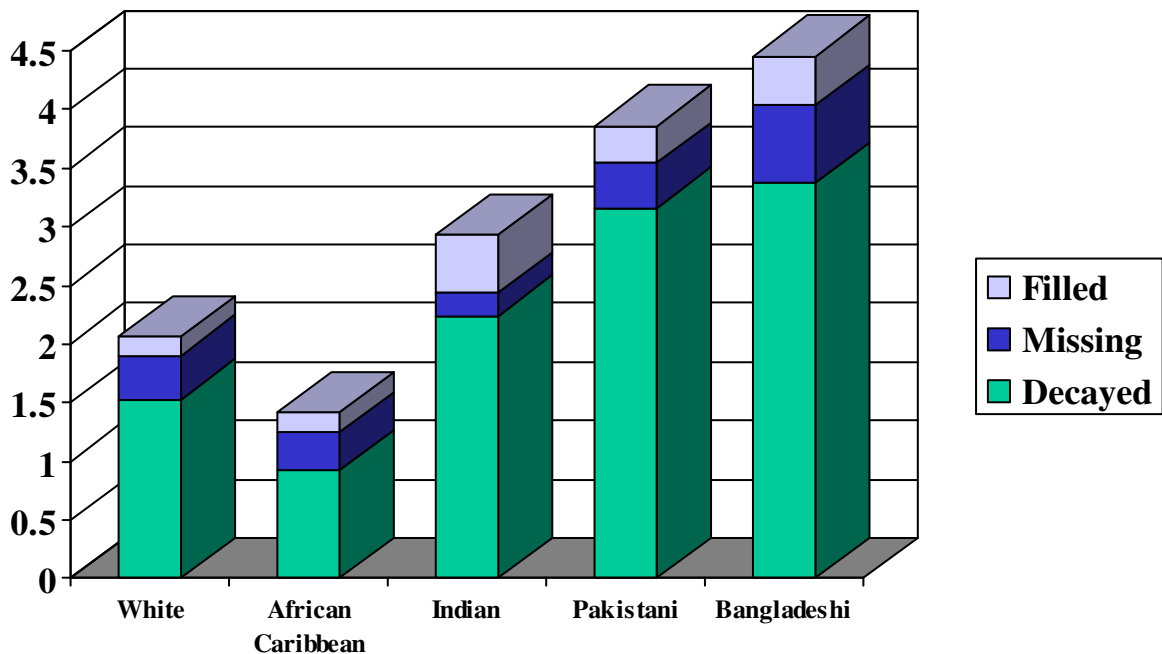
MAP 2



Comparisons of 5-year-old children from different ethnic groups in Leeds have shown that children from a Pakistani or Bangladeshi background have the highest levels of caries and African Caribbean children the lowest (figure 4). Among 12 and 14 year old children however it is the white children who have more decay than either of these minority ethnic groups.

Figure 4

Mean number of decayed, missing and filled primary teeth in 5-year-old children in Leeds in 2003/04 by ethnic group



Comparisons of 5-year-old children from different ethnic groups in Leeds have shown that children from a Pakistani or Bangladeshi background have the highest levels of caries and African Caribbean children the lowest (figure 4). Among 12 and 14 year old children however white children have as much tooth decay as those from an Asian background. African Caribbean still have the lowest level.

Figure 5 Mean number of decayed, missing and filled permanent teeth in 14-year-olds in Leeds in 1986/87 by ethnic group

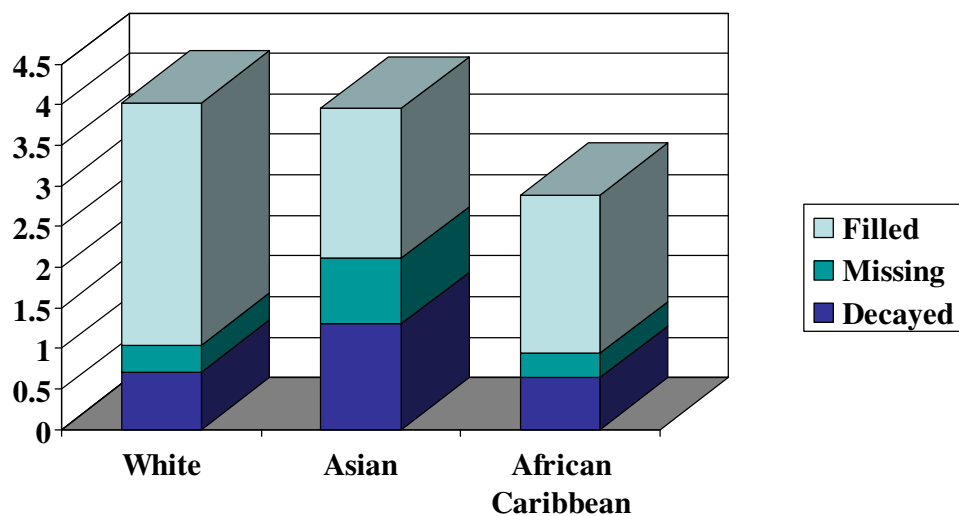


Table 2: National and local targets for adult dental health

Age	Oral health indicator	England 1988	England target 1998	England 1998	Leeds 1992	Leeds target 2000
over 65 years	retain some natural teeth	-	-	-	44%	50%
over 75 years	“ “ “	20%	33%	44%	-	-
over 65 years	have more than 20 teeth	-	-	-	30%	35%
over 75 years	“ “ “	3%	10%	10%	-	-

Table 2 presents some of the data on adult dental health in England and Leeds. Both of the national targets were achieved. Unlike the surveys of dental health in children there is no nationally co-ordinated programme of surveys in adults. The Leeds survey needs to be repeated to ascertain whether there has been a similar improvement in adult dental health in the city.

THE CAUSES OF POOR ORAL HEALTH

Many of the causes of oral disease are the same ones that cause other diseases.

There are thus a number of 'common risk factors' associated with a range of conditions.

1. Diet and nutrition

The frequent and high consumption of sugars is the major cause of dental decay. The majority of the English population consumes more sugar than the recommended 60g per day. Soft drinks, confectionery and biscuits are the main sources of sugars in the diet. There is particular concern about the high levels of consumption among pre-school children, adolescents and older people. Because sugary foods are often cheaper than alternative, more healthy food poorer people tend to consume higher quantities of sugars in their diets compared to those who are more affluent. It is common among some black and ethnic minority groups, especially those from Bangladesh and Pakistan, to give children sweetened drinks in bottles, often at bedtime, until a comparatively late age. This is one of the major reasons for the higher caries rates found in 5-year-old children from those backgrounds. A range of factors influence what people eat and drink but costs, availability, access cultural patterns and clear information are all important.

Tooth wear occurs naturally with time but excessive wear at any age may lead to pain and the need for treatment. In children and young people, tooth wear is more commonly seen as erosion (chemical dissolution of teeth). Children and young people, who consume excessive amounts of acidic fizzy drinks, including diet and sugar free varieties, are more likely to be affected.

Drug abuse is associated with poor oral health partly because drug users often neglect other aspects of healthy living and partly because the drugs cause dental disease. Methadone is frequently prescribed as a sugar-based liquid which causes tooth decay and the use of cannabis can lead to gum disease.

Eating the recommended five items of fruit and vegetables per day is important for promoting good health. At present the consumption of fruit and vegetables nationally is well below the recommended five items per day. The risk of oral cancers can also be reduced when the recommended amounts of fruit and vegetables are consumed.

2. Oral hygiene

The health of periodontal (gum) tissues, the mucous membrane lining the mouth, and the bone supporting the teeth can be affected when the teeth and gums are not brushed regularly and dental plaque (largely composed of bacteria) accumulates. Oral hygiene practices are best learnt in early childhood as part of body hygiene and cleanliness.

The cost of oral hygiene aids, including toothpaste and good quality toothbrushes can result in less affluent families having less efficient oral hygiene practices than those with a higher level of disposable income.

3. Exposure to fluorides

Tooth decay occurs when the bacteria found in the plaque on the surface of the teeth break down sugars to produce an acid. This results in the loss of some of the tooth calcium and phosphate minerals. This 'demineralisation' occurs each time sugary foods and drinks are consumed. Once the plaque acid has been neutralised some of the minerals can be deposited back into the teeth – a process known as 'remineralisation'.

Fluoride tips the balance in favour of this 'repair'. Increasing the availability of fluoride can therefore help prevent tooth decay.

Since the 1970s fluoride has been added to most toothpastes and this is the main reason for the improvement in oral health seen in the UK and elsewhere. Effective, twice-daily tooth brushing has the additional benefit of improving periodontal health. In areas with high levels of disease, water fluoridation is an effective and safe public health measure to reduce decay.

It has been shown that children from Bangladeshi and Pakistani backgrounds tend to start tooth brushing at an older age than white and African Caribbean children and thus do not receive the decay preventing benefit of fluoride toothpaste so early in life.

4. Tobacco and alcohol use

Tobacco use, especially smoking, increases the prevalence and severity of periodontal disease. It is by far the greatest risk factor for mouth (oral) cancer. Smoking 20 or more cigarettes a day increases the risk to six times that of non-smokers. Although less harmful than smoking, the chewing of tobacco products, common in some Asian communities, is also associated with an increased risk of oral cancer. So too is chewing betel. Tobacco use is also linked to a range of other oral health problems and reduces the success rates of dental treatments such as implant surgery.

Excessive alcohol consumption, particularly spirits, is a further risk factor for oral cancer, especially when combined with smoking and a poor diet. Heavy drinkers and smokers are 30 times more likely to develop oral cancer than non-smokers and non-drinkers.

PCTs have an important role with regard to health education on smoking and the provision of smoking cessation services. Government legislation to ban smoking in the workplace will help to reduce the overall prevalence of smoking.

Recent changes in the licensing legislation should be carefully monitored as an increase in binge drinking could lead to a further rise in oral cancer amongst younger age groups.

5. Injury

Traumatised (broken) teeth are a common problem amongst certain groups such as adolescent boys. Fractured teeth can affect people's appearance and self-confidence, and are expensive and difficult to treat. Dental injuries may occur for a variety of reasons including playing contact sports, violence and falls. Binge drinking, violence and non-accidental injury are also causes of facial injury and broken teeth.

6. Other medical conditions

A range of medical conditions may adversely affect oral health. For example people with eating disorders, particularly bulimia may have problems with excessive tooth wear due to the acidic pH of the mouth. People with diabetes often have poor periodontal health and those with chronic diseases who are on multiple long-term medications may have problems with dry mouth.

THE PRINCIPLES OF PREVENTION – COMMON RISK FACTOR APPROACH

1. Improving oral health - principles of good practice

To achieve sustainable oral health improvements and reduce inequalities, action needs to tackle the underlying causes of oral diseases. Contemporary public health research and policy recognises the impact of the broader social, economic and environmental factors in determining health across the population. Focusing on these 'upstream' factors that cause poor oral health and create inequalities is fundamentally important. Actions that only seek to change individual behaviour and lifestyles will usually have only a limited long term effect.

Oral diseases are largely preventable. The challenge is to create the opportunity and conditions to enable individuals and communities to enjoy good oral health. Oral health is an important part of overall good health and well-being and should form an integral part of public health policy and practice. The Ottawa Charter provides a useful framework to develop and implement effective action to promote oral health through healthy public policy, supportive environments, community action, reorientation of health services and personal skills (WHO, 1986).

2. Reducing inequalities and achieving sustained oral health improvements

Action is needed to reduce oral health inequalities across the population. It is unacceptable and unjust that disadvantaged sections of society experience the highest levels of oral diseases. Ironically, in the past, traditional preventive interventions, rather than decreasing inequalities, may have had the reverse effect of widening the health gap between the rich and poor. Oral health initiatives need to link with the government's broader inequalities programme to ensure that the root causes of the differentials are addressed.

No easy or quick fixes exist to promote oral health. Interventions need to be developed that will achieve sustained long term improvements in oral health. Short term changes in oral health knowledge may be relatively easy to achieve but will not have any meaningful effect on behaviours in the longer term. Action is needed to create conditions that support and encourage good oral health. For example policy changes which promote healthier food and drink choices in schools help to create a school environment conducive to good oral health.

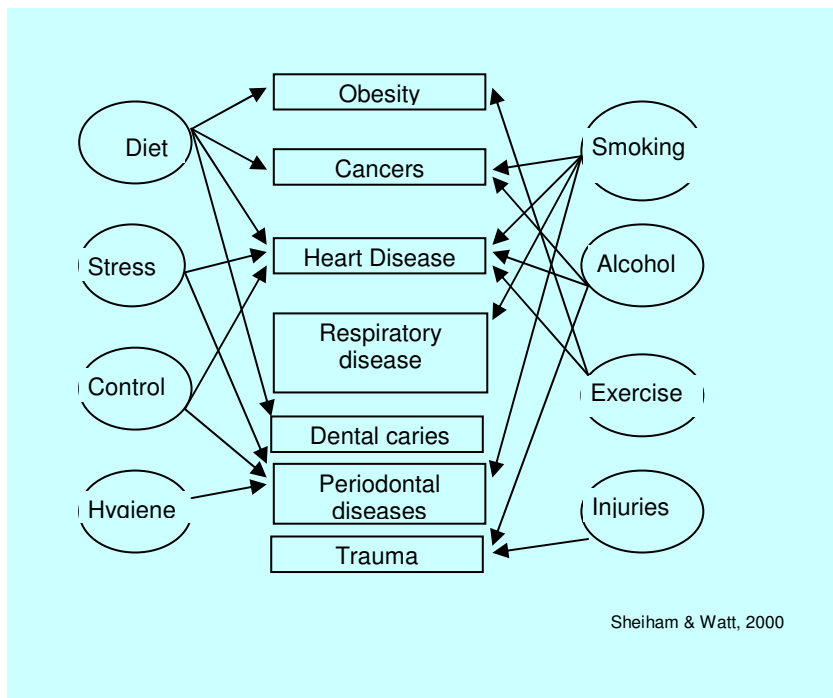
3. Community support

Improving oral health locally is a shared responsibility between the NHS, Local Authority, health professions, individuals and the wider society. Community involvement is essential for achieving sustainable oral health improvements. This is a time consuming process. Health professionals have an important role to play in enabling and encouraging community action.

4. Integrated working

A major criticism of preventive and educational programmes has been the narrow and isolated approach adopted. This uncoordinated approach can at best lead to a duplication of effort, but often in fact results in conflicting and contradictory messages being delivered to the public. The common risk approach recognises that chronic non-communicable diseases and conditions such as obesity, heart disease, stroke, cancers, diabetes, and oral diseases share a set of common risk conditions and factors (Figure n). For example a poor quality diet, smoking, inadequate hygiene, excessive alcohol intake and trauma are factors linked to the development of several chronic conditions including oral diseases.

Figure n Common risk factor approach



The key concept of the integrated common risk approach is that by directing action on these common risks and their underlying social determinants, improvements in a range of chronic conditions will be achieved more efficiently and with greater effectiveness. The common risk approach provides a rationale for partnership working. A wide range of government health initiatives exists, which provide an ideal opportunity to integrate oral and general health actions. It is therefore important that a multi-disciplinary approach is adopted with oral health advice incorporated into general health promotion programmes. Similarly members of the oral health team should be seen as part of the public health workforce and involved, where appropriate, in giving information on general health.

5. Evidence based practice

In recent years, in line with the evidence based movement in clinical medicine and dentistry, the effectiveness of preventive interventions has been scrutinised to determine what interventions are effective, and identify those that produce minimal benefit or even cause harm. A collection of effectiveness reviews of the oral health literature has been published in recent years. These provide useful indications for developing effective practice. A summary of the evidence base for oral health interventions is outlined in Appendix N.

6. Use of fluoride

Fluoride is found in all water supplies. The amount, however, varies from supply to supply. The scientific literature shows very clearly that, although a range of actions are needed to achieve the maximum reduction in tooth decay, the most effective measure is to top up the level of fluoride in the drinking water to one part per million (1ppm) in areas, such as Leeds, where the naturally occurring concentration is less than this optimal level. Because of suggestions that, even at this level, there could be harmful side-effects from water fluoridation there has been considerable research undertaken. This has been carried out in areas where the natural level of fluoride is 1ppm or more and where it has been adjusted to 1ppm for up to 60 years. The published evidence has been reviewed by expert bodies including the Royal College of Physicians, the

National Research Council of the US Academy of Sciences, NHS Centre for Reviews and Dissemination at the University of York, Medical Research Council and the World Health Organisation. All these reviews have confirmed the effectiveness of fluoridation and have concluded that there is no credible evidence of any harmful effect. It reduces tooth decay in both children and adults, with the greatest impact being in areas of social deprivation where the decay rates are highest. It remains the most cost-effective public health measure for reducing tooth decay and, as such, should form a central strand of a strategy to improve dental health.

Where water fluoridation is not undertaken fluoride can be made available to primary schoolchildren through dental (fluoridated) milk. While this provides some benefit it is a poor substitute for fluoridated water because school milk is only available from the age of 3 or 4 years, ceases by the age of 7, only during term time, only 5 days a week and those children who come from the most deprived backgrounds, and who stand to gain the greatest benefits, are the ones most likely to miss school more often because of other health problems.

As well as making fluoride available for ingesting (systemic) it may also be applied to the surface of the teeth (topical). There is an additional benefit from using a combination of systemic and topical fluoride, for example water fluoridation plus fluoride toothpaste.

6. The targeted population approach

There are two complementary approaches to improving oral health:

- The population approach, in which the aim is to lower the average level of risk factor in the population; and
- The high-risk approach, in which people at particularly high risk are identified through screening, and offered appropriate advice and treatment.

Both are important, but initiatives designed to reduce inequalities in health can be structured in another way, the *targeted population approach*. This involves identifying communities at greater risk of disease and using population strategies within these targeted groups. Such an approach is used in a range of health and social policy initiatives such as the neighbourhood renewal strategy.

7. Complementary actions

Public health research has shown that implementing educational interventions alone does not produce sustained improvements in health and has limited effect on reducing the health gap. The WHO and other international organisations recommend the need for implementing a complementary range of actions to promote health. Based upon the Ottawa Charter (WHO, 1986), these include:

- Promoting oral health through public policy: by focusing attention on the impact on health of public policies from all sectors, and not just the health sector.
- Creating supportive environments: by assessing the impact of the environment and clarifying opportunities to make changes conducive to oral health.
- Developing personal skills: by moving beyond the transmission of information, to promote understanding, and to support the development of personal, social and political skills that enable individuals to take action to promote their oral health.
- Strengthening community action: by supporting concrete and effective community action in defining priorities, making decisions, planning strategies and implementing them to achieve better oral health.

- Reorienting oral health services: by refocusing attention away from the responsibility solely to provide curative and clinical services, towards the goal of achieving oral health gain.

8. Partnerships

A core theme of government public health policy is to promote partnership working across the NHS and beyond. The adoption of an integrated common risk approach forms the basis of joint working. Oral health professionals in Leeds need to collaborate with the relevant agencies and sectors to place oral health upon a wider agenda for change.

9. Evaluation

Evaluation is a very important area of practice. Sufficient resources and appropriate methods should be directed to the evaluation and monitoring of all oral health strategies. Both process and outcome evaluation measures should be used.

IMPROVING ORAL HEALTH AND REDUCING INEQUALITIES – PREVENTION AND ORAL HEALTH PROMOTION

What are the Leeds PCTs going to do?

1. Diet and nutrition

- a) In conjunction with others, such as dietitians, school meals advisers, staff in residential homes etc, we will ensure that nutritional guidelines and standards are set to ensure that the oral health implications of dietary policies are taken into account.
- b) We will work to ensure that, as part of the new way of working in primary dental care, the dental team delivers a more preventive orientated service, including the provision of dietary advice, especially for high risk patients.
- c) We will continue to commission oral health promotion activity as currently provided by the Community Dental Service. This will be targeted at those groups with the poorest levels of oral health such as inner city schools. Such activity will include providing information and materials for use by teachers and establishing, wherever possible, a link between what is taught at school and the home.
- d) We will promote breastfeeding and work with health professionals who give dietary advice to their clients, such as health visitors and school nurses, to ensure that they are aware of the importance of restricting the frequency of sugar intake to improve oral health and restricting the consumption of acidic fizzy drinks. Particular emphasis will be given to working with those whose clients include members from the Indian, Pakistani and Bangladeshi communities who are carers of young children.
- e) We will establish links with community and religious leaders within the black and ethnic minority communities to provide advice on the importance of breast feeding and good weaning practice for both general and dental health.
- f) We will work with Sure Start / Children's Centres and community development staff to ensure that oral health is included in their health promotion activities as appropriate and that messages relating to the consumption of sugary drinks and foods and fizzy/acidic drinks are consistent.

2. Oral hygiene

- a) We will ensure that those whose responsibilities include hygiene, such as carers in residential home consider oral hygiene as an integral part of body hygiene. This is important not only to prevent tooth decay but also to prevent gum disease.
- b) We will work with Education Leeds to ensure that oral hygiene is incorporated within teaching on general body cleanliness in Personal and Social Education.
- c) As with diet and nutrition (see above) we will ensure that oral hygiene instruction is included as part of the delivery of the new dental contract, and work with other healthcare professionals so that they are aware of the importance including oral hygiene advice in their every day contacts.
- d) We will continue to use the *Brushing for Life* materials. *Brushing for Life* is a programme, established by the government, which is targeted to the parents of preschool children in areas with poor dental health. Health visitors provide advice on diet and oral hygiene as part of their routine health promotion activity and provide a tooth brushing pack for the infant at about the time that the first teeth erupt in order to establish the habit of regular tooth brushing from an early age. The pack contains a baby toothbrush, tube of fluoride toothpaste and leaflet.

3. Exposure to fluorides

We will promote the appropriate use of fluorides within the community in Leeds. This will include use both topically (on the tooth surface) and systemically (consumed).

3.1 Topical fluoride

- a) When members of the dental team provide oral hygiene instruction this should include advice to brush the teeth twice a day using fluoride toothpaste.
- a) As already stated we will fund the continuation of the *Brushing for Life* programme which includes the provision of a pack containing fluoride toothpaste to the parents of young children, particularly in disadvantaged communities.
- b) We will encourage dental teams to use professionally applied fluoride in the surgery, as appropriate, for patients who are at very high risk from dental decay.

3.2 Systemic fluoride

- a) As already stated the most cost effective measure for reducing tooth decay is through the adjustment of the fluoride level, which in Leeds is currently 0.1 part of fluoride in 1 million parts of water up to the optimal level of 1 part per million (1ppm). This would provide benefit to people of all ages who have their own natural teeth. The Water Act (2003) requires the Strategic Health Authority to undertake public consultation, including consultation with the Local Authority, to ascertain the level of support locally before a decision can be made as to whether there is general support for the measure. We will, therefore, ask the Yorkshire & Humber SHA to undertake this consultation.
- b) Until such time as water fluoridation can be introduced, although recognising that the benefits are less than water fluoridation, we will continue and extend the primary school dental (fluoridated) milk scheme which will confer benefit to children during the years in which they have school milk.

4. Tobacco and alcohol use

- a) We will work with the dental profession to ensure that dentists enquire about smoking / chewing habits whenever taking dental / medical histories. Patients who wish to receive support to quit should then be referred to the local smoking cessation team. Some dental practices may have a member of the dental team who wishes to train as a smoking cessation adviser and we will ensure that this activity is undertaken in conjunction with the local smoking cessation service and that the quit successes count toward the PCT targets.
- b) We will support the broader tobacco control agenda.
- c) We will encourage other healthcare professionals to counsel patients who are at risk of developing oral cancer.
- c) We will participate, as appropriate, in activities in conjunction with the Government / Cancer Research UK mouth cancer awareness campaign launched in November 2005 and with Mouth Cancer Awareness Week activities. This will be undertaken in Leeds to raise people's awareness of the risks of developing mouth cancer, encourage them to maintain healthy lifestyles and to be more aware of the early signs and symptoms of mouth cancer.
- d) We will encourage the training of GPs to undertake the examination of the oral mucosa of tobacco users, heavy drinkers and older people for potentially malignant lesions.
- e) We will encourage and train pharmacists to recognise oral health problems that need referral to dentists or specialist care.
- f) We will encourage the dental team to provide appropriate advice to patients about the sensible use of alcohol.

5. Injury

- a) We will undertake programmes aimed at preventing trauma to the teeth of children and young adults in schools and other locations, such as sports centres. We will also promote improvements in the quality of the environment eg safer play areas, leisure facilities and schools.
- b) Advice on the use of mouth guards/ gum shields will be given to those taking part in contact sports.
- c) Teachers and other carers will be informed about the appropriate first aid treatment when teeth are injured and advised to ensure that early dental treatment is sought.
- d) Road traffic accidents and violence, which are often associated with more major oro-facial trauma, are frequently associated with alcohol. Campaigns aimed at encouraging compliance with seat-belt legislation and the avoidance of alcohol when driving or the excessive consumption of alcohol at any time will be supported.

6. Other preventive measures

- a) We will work with GPs, hospital doctors and pharmacists to encourage an increase in the proportion of sugar free medicines prescribed and sold.

- b) Oral health promotion activities and materials will advise regular visits to a dentist for check-ups in accordance with the guidance on recall intervals from the National Institute for Health and Clinical Excellence (NICE).
- c) In all of the above special attention will be paid to those who are at greatest risk from oral disease or for whom dental treatments may pose a threat to their general health. Such groups will include people with learning disabilities, infirm elderly people, those on long term medication, those with other health problems such as heart conditions, diabetes etc.

SECTION 2 - ORAL HEALTH CARE

1. IMPROVING ACCESS TO APPROPRIATE DENTAL SERVICES

As already stated the main objective of the oral health strategy is to achieve good oral health for the population of Leeds. Various components towards achieving this have been set out. However, it recognised that not all dental disease can be prevented and, whilst we will work on reducing the need, dental treatment will continue to have an important role in maximising the standard of oral health of the community.

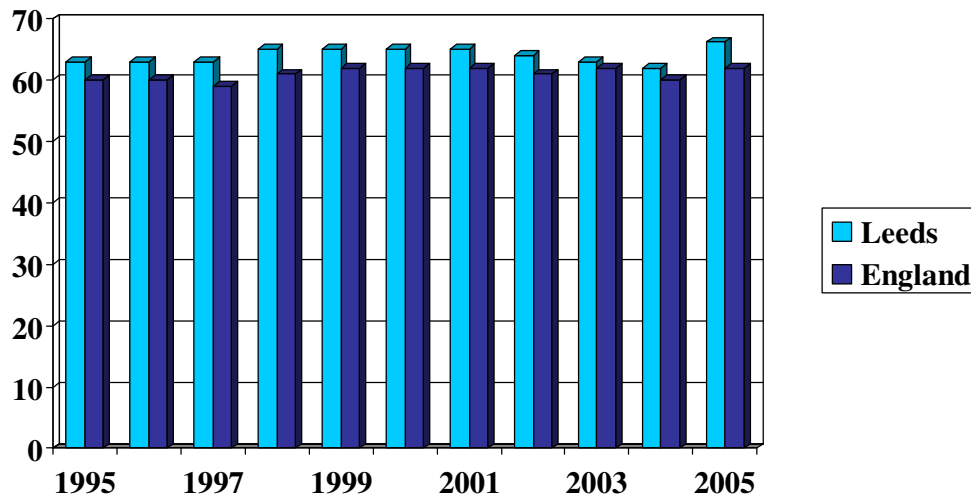
The revision of the oral health strategy provides an opportunity to review what services will be required over the next few years and how and where these might best be provided.

2. THE CURRENT PROVISION OF DENTAL CARE IN LEEDS

2.1 The General Dental Service

The majority of dental treatment is provided by approximately 110 family dentists (general dental practitioners) working in their own surgeries which they provide. The majority of dentists currently work within the General Dental Service (GDS) regulations although 38% of practices transferred over to the new way of working under Personal Dental Service (PDS) regulations in 2004/05. Since the introduction of new GDS and PDS regulations in April 2006 all dentists now receive a set contract value for an agreed level of activity. The philosophy behind the new contract is that it gets dentists off this “fee per item treadmill” and remunerates dentists for the care of an agreed number of patients.

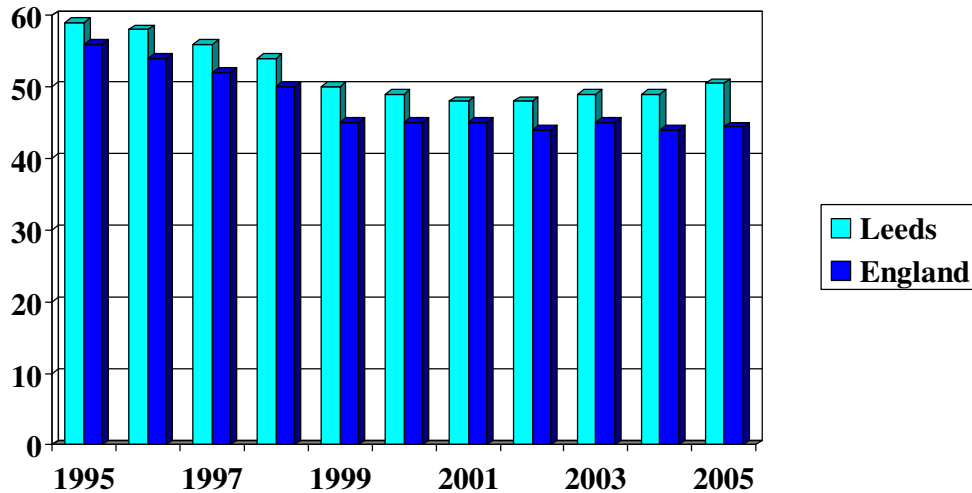
Figure 6 Estimated percentage of children registered with a dentist on 31st March 1992-2005 in Leeds and England



It is recognised that access to NHS dental care has been a problem in some parts of Leeds over recent years. Figure 6 shows the percentage of children registered with a dentist in Leeds for each year since 1995. It can be seen that there has been little change over this period. Figure 7 presents the data for adults. This confirms that there has been a reduction as far as adults are concerned but it does not support the suggestion that there has been widespread withdrawal from the NHS by Leeds dentists. The two Figures demonstrate that there has been an increase in registrations

over the last year and that the proportion of the population registered in Leeds is higher in both children and adults compared to the national average.

Figure 7 Estimated percentage of adults registered with a dentist on 31st March 1992-2005 in Leeds and England



Whilst there has been some reduction in the amount of time that dentists devote to NHS work and a comparable increase in private dentistry

Table 3: Local targets for registrations with an NHS dentist

Age	Indicator	England Dec 1996	England Dec 2000	England Sept 2005	Leeds Dec 1996	Leeds target Dec 2000	Leeds Dec 2000	Leeds Sept 2005
0 - 2 years	% registered	21%	21%	18%	26%	30%	26%	24%
65 - 74 years	“ “ “	43%	42%	44%	43%	48%	45%	50%
75+ years	“ “ “	33%	31%	34%	37%	42%	34%	38%

The 1997 Leeds Oral Health Strategy set local targets for improving the proportion of young children and older people registered with an NHS dentist. Table 3 shows the percentage of the three relevant age groups who were registered. It can be seen that nationally the percentage has fallen by 3% from 1996 to 2005 in the 0-2 year olds and increased by 1% in both the 65-74 and 75+ age groups. None of the targets set for Leeds for 2000 was achieved by that date. However, that for the 65-74 year age group has subsequently been met. The reductions in the percentages in Leeds were similar

to those seen nationally but Leeds still has a higher proportion of each age group registered than the national average.

2.2 The Community Dental Service

The Community Dental Service (CDS) currently provides a mix of primary and secondary care at 14 clinics in Leeds. The CDS treats children and adults with special needs, provides care for those who cannot or do not access care within the GDS, including children from poorer neighbourhoods whose parents do not go to a dentist, and provides specialist treatment, for example, in orthodontics and paediatric dentistry. The service is also able to provide, in conjunction with the hospital service, treatment under general anaesthesia.

The CDS also undertakes a public health role by carrying out screening in schools (dental inspections) and epidemiology fieldwork.

Integrated with the CDS is the Leeds Dental Access Centre which has been funded by the Department of Health to improve access to primary dental care, especially those who need urgent treatment.

2.3 The Hospital Dental Service

Based in the Leeds Dental Institute (LDI), this forms part of the Leeds Teaching Hospitals NHS Trust. In addition to main LDI site a peripheral unit is located at Seacroft hospital.

The LDI provides a full range of specialist dental services namely maxillofacial surgery, orthodontics, paediatric dentistry, restorative dentistry (including periodontics, prosthodontics, endodontics and implantology), oral medicine, dental radiology, and oral pathology. It also provides acute dental care, treatment under sedation and general anaesthesia, and a head and neck cancer service. The regional cleft centre is based in the Leeds General Infirmary.

A large proportion of the clinical activity is undertaken by students as part of the undergraduate (75 permanent places plus 7 temporary places currently) and postgraduate (up to 15 per year) training, and by student dental therapist / hygienists (25 per year). Training of dental nurses (70 per year) and dental technicians (8 full time and up to 10 part time per year) is also undertaken.

The LDI needs to limit the acceptance of patients not needing specialist care to a level which meets the student learning requirement. There is currently a move to providing some of the student clinical training in outreach teaching clinics within the community.

2.4 Emergency Dental Service

In addition to the above three services an Emergency Dental Service for the provision of urgent treatment out of hours is available at Lexicon House, close to the Sheepscar junction, every evening from 7 to 11pm, Saturday, Sunday and Bank Holiday mornings 9am to 1pm and Saturday and some Bank Holiday afternoons 2-6pm. This service is for the relief of pain and provision of other urgent care and does not provide full comprehensive treatment.

2.5 INFORMATION TECHNOLOGY

Currently, many, but not all, dental practices in Leeds have IT equipment within the practice. However, this ranges from older systems which are used for basic practice management to specially designed systems which include the full range of practice management functions as well as clinical records. A high standard of IT hardware, software, N3 connectivity and trained and confident staff within general dental practice

would not only mean that such practices would be able to meet their commitments in relation to Choose and Book, but would also make them better placed to take advantage of any reconfiguration of services. For example, if more dental practices were to offer unscheduled care under nGDS or nPDS, they would be better able to receive incoming bookings electronically and better placed to refer patients to the services offered by others including specialist services such as oral surgery and orthodontics as well as other secondary care provision.

I

IT investment, including the use of electronic patient records, which is currently being introduced into Dental Teaching Hospital such as the LDI might be a model to extend to practices and clinics across the city. This would enable the transfer of patient clinical records between services. In the meantime consideration should be given to the possibility of patient-held records to facilitate such transfer.

2.6 WORKFORCE ISSUES

It is recognised that there is currently a shortage of dental workforce nationally in the UK. The Government has introduced policies to improve the situation. From September 2005 there has been an increase of 170 funded dental undergraduate training places (25% increase). However, it will be 5 years before the first of these additional students graduate. In the short term the Department of Health has initiated a campaign to encourage dentists who have taken a career break to return to work. The recruitment of dentists from countries with a surplus of dentists has also been funded. The number of training places for dental therapists/hygienists has also been increased. These staff take only 2 years to train.

Having Leeds Dental Institute, which trains the full range of dental health care professionals, within the city provides the commissioners and providers with an opportunity to review the best skill mix for providing a top class dental service to the population of Leeds. Such a review should include:

- An assessment of the most effective use of the various members of the dental team
- The number of existing staff likely to retire within the next 5 and 10 years
- The number of staff which need to be recruited and how this might best be achieved
- What specialised services might be required, including hospital and community based dentists who are on one of the General Dental Council Specialist Registers or by the establishment of Dentists with a Special Interest (DwSI) at a sub-specialist level.

2.7 ESTATES

As commissioners PCTs have a duty to ensure that all buildings are fit for purpose. Whilst areas such as Health & Safety and Infection control is reviewed 3 yearly as part of the practice inspection system, the physical buildings can not always meet requirements such as patient privacy and confidentiality.

The majority of dental practices within Leeds operate from former residential or shop premises, and it is likely that there may be ramifications to them arising from the Disability Discrimination Act. While responsibility to meet the requirements of the DDA lie with service providers the PCTs have a role in supporting and advising practices on the implications of their premises.

For the future the PCTs will want to assess premises and funding options, especially in the development of Dentists with a Special Interest and the consideration of how much dental work can shift from Secondary to Primary Care provision.

Where appropriate Leeds PCTs will use the Leeds LIFT schemes to provide premises in a way that will transform how services will be delivered in the future.

3. CURRENT ACCESS STANDARDS FOR LEEDS

The Leeds Primary Care Trusts currently have the following standards within which all residents should be able to obtain dental treatment.

	Emergency	Urgent	Routine
Urban	1 hour 10 miles	24 hours 10 miles	6 weeks 5 miles
Rural	1 hour 14 miles	24 hours 14 miles	6 weeks 10 miles

Urban = inside the outer ring road

Rural = outside the outer ring road

Emergency = life threatening (e.g. severe haemorrhage, severe infection with swelling threatening the airway)

Urgent = needs treatment / advice within 24 hours (e.g. persistent toothache)

Routine = any other dental treatment need

4. NEW COMMISSIONING ARRANGEMENTS FOR PRIMARY DENTAL CARE

The new contractual arrangements from April 2006 offer a number of opportunities for reorientating dental services to have a more preventive focus and for improving access to dental care to meet locally identified needs. PCTs now have a statutory responsibility for providing the dental services to meet all reasonable needs of their populations. Dentists contract with the local PCT to provide an agreed number of units of dental activity (weighted courses of treatment) for an agreed remuneration. Each course of treatment will be classified into one of three bands.

Band 1 - which will cover examination, x-rays, diagnosis and preventive dental work, such as scaling and polishing and the provision of oral health advice.

Band 2 – which will cover simple treatments, such as fillings and extractions.

Band 3 – which will cover more complex treatments involving laboratory work such as crowns, bridges and dentures.

Practices will agree an annual contract value with their commissioning Primary Care Trust and this will be paid in 12 equal monthly instalments. These contract values will be based on previous practice earnings and tied to an agreed level of activity. Activity is to be measured using “Units of Dental Activity” (UDAs), a method whereby various treatments are weighted in relation to their complexity, linked to the new treatment bands. Band 1 treatments will be worth 1 UDA (1.2 in the case of urgent treatment), Band 2 treatments are valued at 3 UDAs and Band 3 treatments valued at 12 UDAs. All existing practitioners are guaranteed a new contract at the level of their previous NHS earnings provided they continue to provide the same level of NHS commitment.

Within these parameters, however, the new contract affords the PCTs a number of opportunities to be innovative and these opportunities will increase over the next few years as new dentists replace those who move away or retire. The emphasis will increasingly be on health gain rather than purely on the provision of treatment.

5. Commissioning Principles

The following principles will be applied to future commissioning arrangements:

5.1 General principles

- All services will be encouraged to adopt a more **preventive approach** including oral hygiene and dietary advice, and the use of fluorides and fissure sealants as appropriate. Practices will be expected to enquire about smoking habits as part of their medical history taking and to give brief advice about smoking cessation to those who smoke. Where members of the dental team have received the relevant training the practice will be commissioned to undertake more extensive smoking cessation activities as part of the PCTs overall smoking cessation programme.
- Experience from PDS pilots has demonstrated that practices which have moved to the new way of working adopt a more modern **evidence-based 'minimal intervention' philosophy** and provide fewer items of treatment within the average course of treatment thus freeing-up capacity that can be used to spend more time on prevention.
- All services will be expected to comply with **guidance from the National Institute of Health and Clinical Excellence (NICE)** including that on patient recall intervals. This means that patients with good oral health and low risk of oral disease can be recalled on a less frequent basis than the traditional 6 monthly interval, whilst being free to attend before their next appointment should they have any dental problems. This will also free-up dentists' time and allow practices to see a broader range of patients and improve access to NHS dental care.
- As far as possible dental care should be provided as a **family based service** to encourage proactive care throughout life. However it is accepted that, in the short term, those practices that currently offer NHS dental care only to children and those adults who are exempt from patient charges should be able to continue to do so. The contract should state explicitly that there should be no additional requirements placed on the patient or their families by the practice (for example it cannot be a condition of a child's entry onto the list, that their parents register for private treatment). The future of these contracts will be reviewed on an annual basis. No practice that currently provides dental care for all groups of patients will have a contract which limits NHS care to children and exempt patients only.
- It is accepted, however, that some members of a family may wish to attend a dentist close to where they work, for example. The **principle of patient choice** will continue.
- New practices will only be commissioned in areas where there is an identified need for improving access, i.e. access will be linked to **identified oral health needs**. Unlike the old GDS, where local Primary Care Trusts had no influence over where individual dental practices were to be located, PCTs will be able to commission the types of dental services they need, in the locations in which they are needed. The principle of patient choice will be balanced by the importance of **addressing existing inequalities**.
- The principle of contestability will be introduced for all new services that are to be commissioned. This means that independent practitioners, Bodies Corporate, the salaried dental service or a hospital service would be able to offer to provide the new service. The PCTs will work with all providers in partnership to ensure that services develop to meet identified needs. This will give the potential to take

advantage of opportunities in relation to skill-mix and commissioning services from dentists with specialist interests. Where appropriate services will be commissioned using a tendering process from those offering **good quality, cost effective services**.

- Services will be commissioned in a way which gives a **cohesive network of care**, based upon care pathways which Leeds residents will be able to understand and access.

5.2 CHILDRENS SERVICES

The Department of Health report *Options for Change* set out the need for the development of clinical care pathways. The University of Dundee dental School has subsequently been commissioned to undertake work on these. In the meantime initial work has been undertaken by the Leeds Dental Institute and Community Dental Service to develop a paediatric dentistry pathway for Leeds.

Background

Tooth decay is a major health problem in children in Leeds

- Decay levels in five year old children has remained relatively static for nearly two decades;
- Over 50% of five year old children in Leeds have experience of tooth decay);
- The average five year old with experience of decay has more than four decayed teeth;
- Around 50% of children with decay end up with pain or infection;
- Recent studies of treatment provided for childhood decay by primary care dentists in the North West of England have failed to demonstrate a reduction in subsequent morbidity. On the other hand, treatments provided by specialist Paediatric Dentists have a high success rate and outcome measures suggest a low incidence of further morbidity;
- Over 80% of children waiting for a general anaesthetic (GA) for dental treatment will suffer further pain or infection if kept waiting for long periods;

General anaesthesia for dental treatment

- Treatment of tooth decay is the most common reason why a child in the UK might require a general anaesthetic.
- Nationally concerns about safe provision of general anaesthesia (GA) in dental practice have resulted in the decision to move all general anaesthetic services for dental treatment into hospitals that have critical care facilities;
- Dental treatment under general anaesthesia is not without risk and is relatively expensive. Hence, alternative strategies should be adopted wherever appropriate and the need to repeat GA should be minimised;
- The need for repetition of GA for the dental treatment of children, especially young children, was high in many of the primary care practices previously offering the service. The repeat rate following Dental General Anaesthesia

where the treatment is both planned and provided by a specialist Paediatric Dentist has been demonstrated to be low;

- GA is only one of the various options for enabling dental care to be provided for children – it is not a “treatment” in itself. Hence, it cannot be considered in isolation from other management strategies. The new guidance makes it incumbent upon the dentist providing treatment under GA to have fully considered and discussed other approaches with the parent first.

Specialised Dental Consultation and Treatment Services for children

- Duplication of, and changes in, service provision have led to confusion amongst primary care dentists and inefficiency in service provision. Hence, the current structure of specialised dental services for children in Leeds clear pathways for efficient referral and management of children with specialised dental problems have been developed;
- Accurate data must be collected to ensure that Department of Health quality, waiting time and choice targets are all met in the most efficient manner.

Aims of the paediatric dentistry pathway

The pathway (Figure n) sets out a protocol for the management of children referred for specialised dental care. These proposals have been developed with the following principles in mind:

- Children with routine dental needs should, wherever possible, be managed in the primary care services;
- Primary care practitioners need to be provided with information to enable efficient and appropriate referral of children requiring specialised dental opinions;
- Parent and children should be given choice of where to be seen for consultation and (where appropriate) subsequent treatment wherever possible;
- Accurate data must be collected to enable appropriate services of adequate capacity to be developed and maintained. This may include future expansion or contraction of services to meet changing needs in the child population;
- Multiple specialist consultation should be avoided. Children should only normally require one specialist opinion prior to being directed to appropriate treatment/management;
- There is a need to identify appropriate teaching material for Specialist Registrars and postgraduate/undergraduate students;
- Children who have a medical condition where dental disease places their general health at risk need to access care rapidly.

The Way Forward

The pathway has now been agreed and is in the process of being implemented, this will be kept under a regular review and inform future commissioning decisions.

5.3 GENERAL DENTAL CARE FOR ADULTS

The main aim of the strategy is to encourage proactive oral health care throughout life. To support this PCTs will commission general dental services throughout Leeds to provide choice of access for patients and ensure that they are empowered to exercise this choice and understand the options available.

To ensure that services are accessible existing NHS provision has been mapped geographically, whilst a clear priority will be to address gaps in those areas with poor oral health, a baseline level of provision will be agreed as a minimum for all areas in Leeds. Services in future will be then be commissioned to ensure that any gaps start to be closed.

5.4 COMMISSIONING UNSCHEDULED DENTAL CARE

Two aspects of unscheduled care need to be considered, namely in-hours unscheduled care and out of hour's unscheduled care, capacity and demand on one clearly has a direct impact on the other.

From April 2006, PCTs have the responsibility for the provision of out-of-hours dental services for patients who need urgent dental advice or treatment. Providing these services for their own patients will no longer be a requirement of GDS contracts or PDS agreements. It will be for PCTs to agree with local practices what their opening hours are, but arrangements for cover for evenings, nights, weekends and public holidays will be the responsibility of the PCT.

A recent audit of the use of the current out of hours (OoH) emergency dental service in Leeds has shown that 77% of patients attended because of toothache and that almost 60% of these had had the problem for 2 days or more. 82% of patients are treated by giving a prescription, usually for an antibiotic. This audit shows that almost all of the patients who attend the emergency dental service are not real emergencies but patients who need access to urgent care within 24-48 hours. If such care was to be more easily available in-hours there would be less need for out of hours provision during weekday evenings.

The Department of Health has recently (December 2005) issued guidance on commissioning OoH dental services. This guidance states that "PCTs should come together under the umbrella of the Strategic Health Authority to consider how best to manage or redistribute resources to meet local needs." In order to assess the effect of the new dental contract and any increase in the provision of in-hours treatment for patients needing urgent attention the current service will continue for a period of at least six months. During that time the Leeds PCTs will, in conjunction with other PCTs in Yorkshire & Humber SHA, consider the options for OoH provision so that appropriate care to meet patients' needs is provided whilst ensuring that no more complex needs are generated because of a delay in receiving such advice or treatment.

The Way Forward

The PCTs will review the existing provision for urgent care during 2006, and develop an integrated care pathway for those requiring urgent care which encourages the population of Leeds to proactively access routine services in the future.

5.5 SPECIAL NEEDS

Special needs dentistry includes a number of client groups e.g. physical disabilities, learning disabilities, the elderly and phobic patients.

The PCT will support these client groups in accessing general services where possible by encouraging services to review their training requirements, protocols and facilities to meet needs of these patient groups. Specialist care will also be commissioned in recognition of the complex needs of some patients through the development of integrated care pathways.

Particular emphasis will also be given to ensuring that carers, residential and nursing homes recognise the oral health needs of these groups and encourage good oral health.

- Domiciliary Care

A new policy is being developed to ensure that domiciliary care is available where appropriate and necessary. However the emphasis will be on providing services which enable patients to access dental care in appropriate clinical facilities with the requisite transport to support this. To support this some of the new LIFT facilities for CDS have been commissioned to incorporate specialist hoists.

5.6 ORTHODONTIC CARE

Orthodontic services are commissioned from specialist practitioners and dentists who are non specialists and usually carry out a mix of orthodontic and generalist services. Services are also provided by consultant orthodontist in a hospital setting where the patients generally have more complex treatment requirements. The way patients access care is not restricted to the PCT area in which they reside and there is no intention to change this arrangement.

Orthodontic need can be assessed by using the IOTN (Index of Orthodontic Treatment Need). Those graded 4 and 5 having the greatest need, 3 with a borderline treatment need and 1 and 2 little or no need. The aesthetic component of the index looks at the aesthetic acceptability acceptance of the teeth with 10 being least attractive and 1 most. Only treatment with IOTN grading of 3-5 with an aesthetic component of 6 or above will be commissioned. Based on national public health data it is anticipated that this will equate to 33% of the 12 year old population requiring treatment as IOTN category 4, 5 and 44-50% IOTN 4,5, 3 with aesthetic component >6. Although there is a gap between the level of service that is commissioned in Leeds against the assessment of need, Leeds has the greatest level of provision across West Yorkshire.

Adults will only be accepted for treatment in exceptional circumstances with the need established by a hospital consultant.

Non specialist dentists that provide a significant level of activity using fixed appliances will comply with the same commissioning standards and clinical outcome standards. These practitioners will work to achieve accreditation as a DwSI and have an ongoing requirement to maintain agreed level of competence

The structure of the new dental contract for primary care means that less care can be provided from the funding available. Without additional investment this will lead to an unavoidable reduction in level of treatment to what has previously been provided. Further work is needed to look at the referral pathway to ensure only patients prioritised by clinical need are referred for treatment in line with commissioning criteria. Without additional investment this will lead to a growth in the waiting list for treatment. To reduce costs where

possible we will ensure that services are commissioned in a cost effective manner, including looking at skill-mix opportunities.

5.7 ORAL/MAXILLO-FACIAL SURGERY

These specialist services will be integrated into care pathways for oral health.

Currently both Adult and Paediatric patients face lengthy waits before being able to access treatment of this nature. This is due in part to the delivery of such treatment being restricted to outlets of secondary care, such as the Leeds Dental Institute. As part of the integration, current commissioning arrangements will be reviewed to ensure that capacity and demand are in balance, and that services are cost effective. This review will include considering whether to widen access to such treatment out of the secondary care setting.

Preliminary discussions have established that there are a number of general dental practitioners who would be interested in delivering these specialist services in a primary care setting; as dentists with a specialist interest. There remain a number of issues that would need to be explored before commissioning such services can be considered, these include:-

- The required levels of qualifications and experience required by practitioners.
- kaArrangements for ongoing clinical supervision, review and CPD.
- Value for money

However, if these issues can be satisfactorily resolved, the opportunity remains to provide a greater breadth of services, and extend patient choice and convenience.

5.8 SCREENING

Currently the CDS screens children in some primary schools. From studies carried out in Leeds and elsewhere the effectiveness of the current screening programmes is somewhat doubtful. However, it is likely that the outcome from screening in schools could be improved by combining the screening with oral health education activities and a more pro-active follow-up of those children who were found to need treatment but who have not received it. Screening should be undertaken only in those schools with the poorest levels of dental health. The selection of schools to screen should be based on the results of the routine epidemiological surveys.

In addition to screening in schools there may be other groups for whom screening might be beneficial in detecting oral conditions which need to be treated. Older people living in residential or nursing homes do not always receive regular dental care and commissioning screening in such locations could detect oral disease, including mouth cancer, at an earlier stage and lead to an improved prognosis for a successful outcome.

5.9 PATIENT ADVICE

To ensure that Leeds residents can navigate the various dental services which are available to them Leeds Dental Advice Line has been established with a freephone number.

This Service has two primary functions:-

- a. To take details of those seeking access to routine dental care, prioritise and inform

them as and when service become available.

- b. To support individuals seeking urgent care.

This service has been commissioned from Leeds PALS and works alongside other, general services e.g. NHS Direct. All providers of care are expected to work in partnership with the helpline to ensure that support remains up to date.

SYNOPSIS OF ACTIONS

This section sets out the main actions which need to be taken to implement this strategy showing the partners with whom the PCTs will work.

1 Improving diet and reducing sugars intake

- Promoting breastfeeding and recommended weaning practices
- Reducing the frequency and amount of added sugars consumed in line with Department of Health target (11% of energy from added sugar)
- Increasing the consumption of fruit and vegetables to at least 5 portions a day
- Reducing the consumption of acidic soft drinks
- Promoting the use of sugar free medicines

Topic	Good Practice	Target Group	Participants
Infant feeding	Promote breastfeeding in line with DH recommendations. Ensure weaning advice confirms to COMA recommendations. Ensure oral health input into local infant feeding strategies and guidelines	Nursing mothers and babies	Midwives, health visitors and GPs Sure Start Community groups Children's Centres Public Health Practitioners Dentists and DCPs
Policy guidelines	Promote the development and adoption of nutrition and healthy eating guidelines which include action on sugars in organisations where food and/or drinks are prepared and/or sold.	Pre-school children School children Students Patients Prisoners Older people in care and nursing homes	Preschools and nurseries Schools and colleges Hospitals Prisons Leeds City Council Public Health Practitioners Dentists and DCPs

2 Improving oral hygiene

- Encouraging the early adoption of oral hygiene practices in young children
- Promoting effective oral hygiene self care practices across the population
- Supporting parents, health professionals and carers of people who need help in maintaining their oral hygiene

Topic	Good Practice	Target Group	Participants
Early tooth brushing	Encourage parents and carers to start tooth brushing with a fluoride toothpaste within the first year of child's life	Parents and infants	Health visitors and GPs Sure Start Community Groups Children's centres Dentists and DCPs
Body and oral hygiene	Incorporate oral hygiene teaching within general body cleanliness in Personal and Social Education teaching. Ensure individuals in residential and care settings	Schoolchildren	Teachers Dentists and DCPs

	have access to tooth brushing facilities and advice on oral hygiene	People in residential care	Leeds City Council Staff in residential homes
Training and support	Improve the effectiveness of oral hygiene instruction provided by oral and other health professionals.	Whole population	Nurses, midwives and health visitors Carers Dentists and DCPs

3. Optimising exposure to fluorides

- Encouraging the use of fluoride toothpastes across the population, especially young children in disadvantaged areas.
- Asking the SHA to undertake consultation on water fluoridation and if strong local support is expressed, to ask Yorkshire Water to implement the measure.

Topic	Good Practice	Target Group	Partners
Water fluoridation	In line with government legislation ask the SHA to explore the feasibility of water fluoridation and undertake a public consultation to assess local support	Whole population	SHA Yorkshire Water Dentists and DCPs Public Health practitioners
Fluoride toothpastes	Increase the use of fluoride toothpaste, especially by young children in disadvantaged communities. Ensure recommendations on appropriate use of toothpastes are given by health professionals and other care staff. Assess the feasibility of distributing fluoride toothpastes and brushes to young children in disadvantaged communities.	Whole population, especially young children in disadvantaged areas	Health visitors and GPs Sure Start Community groups Children's Centres Public Health practitioners Dentists and DCPs
Other fluorides	Development of other options to deliver fluorides where required e.g. varnishes with special needs groups, fluoride milk in schools.	High risk populations	Education Leeds Leeds City Council Dentists and DCPs

4. Tobacco control and promoting sensible alcohol use

- Supporting smokers to stop
- Referring motivated smokers who wish help in stopping to local NHS Stop Smoking Services
- Improving early detection of early stage malignant lesions and referral to specialist care
- Encouraging sensible drinking patterns of alcohol consumption

Topic	Good Practice	Target Group	Partners
Smoking cessation	Encourage dental teams to routinely enquire about their patients' use of tobacco and to give advice and support on stopping When appropriate refer smokers to local NHS Stop Smoking Services.	Smokers	Dentists and DCPs NHS Stop Smoking Services Public Health practitioners

Smokeless tobacco	Encourage dental teams to provide advice and support to individuals to stop the use of smokeless tobacco. Support community wide initiatives on tobacco use	Users of smokeless tobacco	Dentists and DCPs Public Health practitioners Community groups
Tobacco control	Support broader tobacco control agenda	Whole population	Dentists and DCPs Public Health practitioners Professional Associations e.g. BDA Industry/Employers
Early detection	Train and support dentists to examine routinely the oral mucosa of all patients. Encourage and train GPs to undertake examination of the oral mucosa of tobacco users, heavy drinks and older people.	Smokers, heavy drinks and older people	Dentists and DCPs GPs Pharmacists Postgraduate Medical and Dental Deans Leeds Dental Institute

5. Reducing dento-facial injuries

- Creating a safer environment for play, recreation and travel
- Reducing trauma caused by violence and binge drinking
- Implementing guidelines on first aid for dental injuries

Topic	Good Practice	Target Group	Partners
Safe environment	Promote improvements in the quality of the environment e.g. safer play areas, leisure facilities, schools and colleges Promote the use & availability of gum shields	Children and young people	Dentists and DCPs Schools Sports and leisure organisations Leeds City Council Public Health practitioners
Reducing violent trauma	Support policies on reducing binge drinking amongst young people Train and support dental teams in the recognition of children at risk of non-accidental injuries	Young people and heavy drinkers Children	Dentists and DCPs Leeds City Council Police Drinks Industry Public Health practitioners
First aid guidelines	Ensure schools, colleges and other settings are aware and adopt guidelines on first aid for dental injuries	Children and young people	Dentists and DCPs Schools Sports and leisure organisations Leeds City Council Public Health practitioners

6. Professional training and support

- Developing the health promoting knowledge and skills of the dental team
- Incorporating oral health input into the training of other health professionals
- Providing support if implementing and evaluating the oral health component of the LDPs
- Developing oral health links with other areas of health improvement

Topic	Good Practice	Target Group	Partners
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Capacity building	Provide high quality training to develop dental teams' health promoting knowledge and skills. Expand health promotion input into undergraduate and other training programmes. Develop role of DCPs in delivering high quality health promotion	Dental students Dentists DCPs	Dentists and DCPs Leeds Dental Institute Postgraduate Dental Dean Trainers SHA Workforce Development Confederation
Training	Expand and develop oral health input into professional training of relevant health workers	Midwives and health visitors GPs and practice nurses Pharmacists Sure Start staff Teachers Carers	Dentists and DCPs Universities and colleges Trainers Postgraduate Dean SHA Workforce Development Confederation
On-going support	Improve provision of health promotion resources and materials Provide evidence-based guidelines for future interventions	Dentists and DCPS	Health Promotion Units Leeds Dental Institute NICE Regional Directorate of Public Health
Links	Review common risks for oral and general health and develop shared agenda for action	Public health	Dentists and DCPs SHA/Regional Directorate of Public Health

7. Commissioning

Topic	Planned Action	Target Group	Partners
Integrating dental care	Development and regular review of care pathways for all client groups	All dental service providers	CDS, LDI, GDPs, LDC
Access	Ensure services are available to all Leeds residents and reflect oral health needs.	General dental services	
Urgent Care	Review the current provision		
Orthodontic Care	Manage capacity & demand		
Screening	Review programme to ensure this captures the oral health needs		
Domiciliary Care	Review current policies to maximise cost effectiveness		

