West Yorkshire Health and Care Partnership

NHS West Yorkshire Integrated Care Board

Meeting name:	NHS West Yorkshire Integrated Care Board
Agenda item no.	6
Meeting date:	16 May 2023
Report title:	Dentistry and Oral Health in West Yorkshire
Report presented by:	Ian Holmes, Director of Strategy and Partnerships, NHS West Yorkshire Integrated Care Board
Report approved by:	Ian Holmes, Director of Strategy and Partnerships, NHS West Yorkshire Integrated Care Board
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Purpose and Action			
Assurance ☐	Decision ☒ (approve/recommend/ support/ratify)	Action ☒ (review/consider/comment/ discuss/escalate	Information ☒

Previous considerations:

The NHS West Yorkshire Integrated Care Board (WY ICB) has previously (21 March 2023) agreed to the delegation of responsibility for commissioning pharmacy, optometry and dental services across West Yorkshire.

Executive summary and points for discussion:

The NHS WY ICB has recently assumed responsibility for the commissioning of dental services across West Yorkshire (WY). Oral health and access to dental services is a significant concern for the people we serve. It is a consistent theme in insight and engagement work and has a significant impact on health and wellbeing. This paper has been prepared to support the Board to explore its position and ambitions on improving NHS dentistry across West Yorkshire.

This paper provides:

- A background to dental services, including the national and contractual context, as well as circumstances across WY
- A summary of oral health and prevention activities and priorities, including the link to local authorities
- A summary of flexible commissioning and access priorities, with emphasis on potential opportunities to explore and expand flexible commissioning practices across WY

- Context on workforce priorities at present, and future areas of opportunity as an ICB
- Information on the capacity of the WY dental commissioning team, as part of wider Yorkshire and Humber arrangements, and necessary capacity growth requirements
- Recommendations for the Board to consider and proposed actions to support.

Which purpose(s) of an Integrated Care System does this report align with?

☒ Improve healthcare outcomes for residents in their system

☒ Tackle inequalities in access, experience and outcomes

☐ Enhance productivity and value for money

☐ Support broader social and economic development

Recommendation(s)

The Board is asked to:

- **Support exploration of a collaborative approach with the WY local authorities to the commissioning evidence informed oral health prevention interventions that support a common risk factor and life course approach.**
- **Support the approach to extending the current flexible commissioning practices beyond the current scope (in a way that is consistent with the national contract), working with Local Dental Committees and other partners to build on existing good practice.**
- **Support the development of further plans to invest the additional £4.5m of estimated underspend in the areas identified in the paper.**
- **Support the development of a West Yorkshire dental workforce plan covering the areas described in the paper.**
- **Support the recruitment of 6.5 WTE additional posts to the commissioning team for Yorkshire and Humber team (recognising that each ICB will need to fund a 1/3 share of this).**
- **Through the ongoing operating model review, support the proposal that each place identifying a named lead to act as the connecting point with the dental commissioning team.**

Does the report provide assurance or mitigate any of the strategic threats or significant risks on the Corporate Risk Register or Board Assurance Framework? If yes, please detail which:

N/A

Appendices

Appendix A: Locality profiles

Appendix B-D: Examples of existing oral health promotion schemes.

Acronyms and Abbreviations explained
1. WY – West Yorkshire 2. ICB – Integrated Care Board 3. UDA – Unit of Dental Activity 4. OHNA – Oral Health Needs Assessment 5. Y&H – Yorkshire and Humber 6. LDN – Local Dental Network 7. MCN – Managed Clinical Network

What are the implications for?

Residents and Communities	Opportunities to improve dental services across WY in line with what people continue to tell us, prioritising access and tackling oral health inequalities.
Quality and Safety	Poor access to dental services can lead to complications and exacerbations of conditions. There is also a link between poor oral health and wider health and wellbeing.
Equality, Diversity and Inclusion	Opportunities through tackling inequalities, adopting a data-driven approach and supporting practices in areas of high need/deprivation to enhance the inclusivity of our services and ensure equitable access. It will be important to ensure that engagement continues to involve patients from all backgrounds to develop and review improvements against diverse needs.
Finances and Use of Resources	The paper sets out areas to discuss and actions that support that could require an approach to the use of resources that has moderate risk, and that could have broader financial implications for the ICB.
Regulation and Legal Requirements	The ICBs responsibility for commissioning dental services is underpinned by the Health and Care Act 2022 and delegated that the Board agreed to in March 2023.
Conflicts of Interest	
Data Protection	

Transformation and Innovation	The paper sets out several opportunities to transform dental service delivery in WY, specifically focusing on access, inequalities, prevention and investment. Dental innovation will not occur in isolation of wider system transformation.
Environmental and Climate Change	
Future Decisions and Policy Making	
Citizen and Stakeholder Engagement	Multiple sources of engagement have highlighted improvement of and access to dental services as a key priority for the people of WY.

1. Purpose

1.1. This paper provides an opportunity to the Board to consider its position and priorities regarding dental services across West Yorkshire (WY).

1.2. The paper describes ongoing work across WY, the current position and challenges, areas of opportunity to improve dental services through system working and sets out a series of recommendations for approval.

2. Background

2.1. Following agreement at the Board on 21 March 2023 to the delegation of commissioning responsibility for pharmacy, optometry and dental, the ICB now holds responsibility that covers the improvement of dental services.

2.2. Improving dental services is a priority for our partnership. Engagement on our refreshed strategy highlighted significant public and partner concern around access to dentistry, with the ability to make an appointment with a dentist and access to urgent dental care identified as key issues. It is a common theme in Healthwatch engagement work, and an issue highlighted frequently through elected members and local health scrutiny committees. We also know that poor access to dental services increased the demand for other primary and secondary care services.

2.3. The conditions of dental service delivery are determined nationally through contractual frameworks and as set out in the NHSE Policy Book.

2.3.1. Primary care general dental services (or 'high street' dentists) are contracted through the General Dental Services and Personal Dental Services contracts.

2.3.2. Community dental services, which mostly provide care to those with additional needs, are contracted primarily through the Personal Dental Services contract.

2.3.3. Acute and urgent dental services are provided on a sessional basis within existing contractual frameworks.

2.4. The existing nationally specified contractual arrangements are widely viewed as a barrier to delivering better care. Whilst set nationally, there may be scope for the ICB to influence upward and be creative in making the contract work better, ensuring prevention-based care, encouraging greater use of skill mix. The limitations include:

2.5.1. No fixed UDA rate, and variability across/within places, which can disincentivise the provision of NHS dentistry and hinder access The UDA rate was set in 2006 based on the pattern of practice in 2005 as a measure of stability for dental practices (even then it sealed in some inappropriate patterns of practice). Since 2006 many of those practitioners have retired and been replaced by new graduates with different training and different patterns of practice.

2.5.2. Practices only being required (and remunerated) to provide episodes of treatment, rather than continuity (e.g. through a patient list)

2.5.3. Focus on and remuneration for individual treatments and patient throughput challenges the ability to treat patients with complex needs

2.5.4. No consideration of or weighted funding to account for practices delivering care in areas of most inequality and deprivation.

2.5. Local authorities hold responsibility for the public health elements of dental care focus on oral health improvement.

2.6. **Dental Services in West Yorkshire**

2.7.1. Across WY there are 294 active dental contracts, with 260 dental practices. By place, practice numbers are:

- Bradford: 55
- Calderdale: 23
- Kirklees: 51
- Leeds: 95
- Wakefield: 36

2.7.2. The monetary value of UDA rates range between £24.09 to £43.29 – i.e. an almost two-fold variation in price for essentially the same activity.

2.7.1. The Oral Health Needs Assessment (OHNA) outlines specific local place context, good practice, opportunities and population need. This in turn formulates the way in which oral health inequalities are addressed, approaches to prevention are formed and the development of priorities to meet population need. One of the components of OHNA is the regular epidemiological surveys that are co-ordinated and published nationally. The recently published results of the survey of 5-year-old children shows only one of the 5 places in WY participating. We are keen to work to with Local Authorities to improve this position.

2.7.3. The locality profiles (Appendix A) that are formed through the OHNAs set out a more detailed view of the context across our five local authority footprints.

2.7.4. Some positive elements across all localities include:

- A good distribution of practices reflecting population density
- Access to primary care commissioned specialist orthodontic and minor oral surgery practices
- Strong multi-professional, local authority led Oral Health Action Groups to support planning and commissioning.

2.7.5. There are significant challenges evident across all localities in West Yorkshire, including:

- Children's oral health
- Access to data that enables identification of and action to tackle inequalities
- Managing dental needs of an ageing population, with associated cost and complexity
- Lengthy waits for general anaesthesia
- Levels of access to dental care by local populations
- Variable UDA rates across and within localities.

2.8. Community dental services provide care to those with additional needs and are the primary gatekeeper of referrals to dental general anaesthetic treatments. These services experience significant waiting times which require resolution across WY. Evidence suggests that there is comparative underfunding of these services in West Yorkshire. Further work is needed to understand the level of unmet need across our ICB footprint.

2.9. Inequalities in oral health exist, with those in the most deprived areas experiencing poorer oral health across all age groups. Barriers to dental service use are visible when viewing by protected characteristics and for vulnerable groups at individual, organisational and policy level, although availability of data is variable.

2.10. There is evidence of oral health inequalities associated with disability in terms of caries, dental access, tooth loss, traumatic dental injuries, oral health behaviours and quality of life.

2.11. In commissioning oral health preventive interventions and dental care services particular consideration should be given to those that have both the greatest dental need and experience challenges in accessing routine and urgent dental care. This should include individuals and communities that are deprived, vulnerable children known to the social care system, individuals with severe physical and/or learning disabilities, those with poor mental health, older adults, homeless, asylum seekers, refugees and migrants.

2.12. Data and evidence surrounding oral health inequalities is variable and complex, but we know that they also exist in relation to oral cancer as well as in vulnerable groups with long-standing medical conditions, substance misuse, prisoners/prison leavers and Gypsy, Roma and Traveller communities.

<u>Dental Clinical leadership</u>

2.13. The Yorkshire and the Humber Dental Clinical Leadership Group provides robust clinical leadership, direction, and oversight of all Local Dental Network (LDN) and

Managed Clinical Network (MCN) workplans in Yorkshire and the Humber (Y&H), as informed by the NHSE YH Dental Commissioning Strategy.

2.14. The group ensures robust arrangements are in place to develop, implement and oversee workplans, ensuring that clinical leadership supports the dental commissioning approach and implementation of the Dental Commissioning Strategy across the 3 ICS footprints in Y&H.

3. Oral Health and Prevention

3.1. Oral health improvements, preventing poor oral health and tackling inequalities in oral health are key priorities with ongoing work across WY.

3.2. Poor oral health is largely preventable. Risk factors for oral health include those prevalent across other physical health issues – including smoking, alcohol consumption and a poor diet. Opportunities to adopt a common risk factor approach underpinned by 'Making Every Contact Count' should contribute to both general and oral health improvement.

3.3. Adopting an approach that embraces matrix working across system partners and a life-course approach could bring significant benefits in tackling oral health inequalities, delivering OHNA priorities for intervention and broadly enable people to live well.

3.4. Data on the general state of oral health from local OHNAs indicates that:

3.4.1. Those living in the most deprived areas suffer poorer oral health

3.4.2. By age 5, 29% of children in WY experience tooth decay (with a range between WY local authority areas of 25-37%)

3.4.3. Tooth decay is the most common reason for admitting those aged 6-10 years old to hospital

3.4.4. Rates of oral cancer is significantly higher in WY than nationally

3.4.5. There is evidence of inequalities in oral health by disability and other marginalised groups.

3.5. Despite evidence of challenge, there is an established oral health improvement infrastructure across each WY local authority area and several examples of good practice. Each local authority commissions evidence informed oral health prevention programmes, but there is variability between areas on the scope and targeting of these programmes with most focused on children. There is a considerable amount of research happening across WY to improve the evidence base, including:

3.5.1. BRUSH – optimising toothbrushing programmes in nurseries and schools to reduce tooth decay in children. Through engagement with key stakeholders (commissioners, teachers, parents, children etc.) a toolkit is being finalised

to optimise implementation and sustainability of supervised toothbrushing programmes over time (Appendix B).

3.5.2. HABIT – a programme to upskill health visitors to have effective oral health conversations to prevent tooth decay when visiting families with young children aged 0-24 months in Bradford. The programme includes training for professionals and parent-facing resources (Appendix C).

3.5.3. ToothPASTE – tackling tooth decay in children with autism who are less likely than other children to visit the dentist, and twice as likely to require treatment under general anaesthetic. Co-designed a support package with children with autism, parents/professionals that care for them and experts to address barriers to good oral health (Appendix D).

3.6. By working collaboratively across WY there would be opportunities to implement evidence informed prevention programmes at scale. This could reduce inequalities in access to such programmes for the WY population and harness the potential to source resources (e.g. toothbrushes and toothpaste) in bulk. A better data infrastructure that underpins the prevention and inequalities work would allow more effective evaluation of programmes.

3.7. The most significant public health intervention in relation to oral health is water fluoridation. One of the measures in the Health and Care Act 2022 was the transfer of responsibility for community water fluoridation from local authorities to the Secretary of State for Health and Social Care. It is proposed that conversations take place with the Department of Health and Social Care to assess the feasibility of West Yorkshire becoming a region for water fluoridation.

3.8. **The Board is asked to:**

- **Support the exploration of a collaborative approach with the WY local authorities to commissioning evidence informed oral health prevention interventions that support a common risk factor and life course approach.**

4. Flexible Commissioning and Access Schemes

Flexible commissioning

4.1. Flexible commissioning is an approach to commissioning dental services differently and for greater patient benefit to meet their needs more appropriately. It aims to work around some of the rigidities of the national contract by using a proportion of the contracted activity (UDAs) on locally agreed schemes. The approach aims to improve access to dental services and the delivery of evidence-based prevention in primary dental care, whilst supporting practices to deliver their contract commitments by utilising skill mix.

4.2. Ongoing review demonstrates that it is possible to commission dental services differently in a format that supports preventative care to reduce inequalities, offer

access to new patients and develop the dental workforce. These schemes are strongly supported by local dental committees and support better staff retention.

4.3. At present there are 56 practices across West Yorkshire engaged in flexible commissioning, with the scheme extended to 31 March 2024. The value of these schemes is limited to 10% of the contract value. There is significant appetite to increase the scope of the programme covered by flexible commissioning, within the constraints of the national contract.

4.4. As part of this we would look to engage with practices in areas of high need that do not currently have a practice on the programme. Currently, not all practices in these areas will meet the eligibility criteria but there is an opportunity for the ICB to review this and develop measures that consider outcomes rather than a focus on the target. These schemes will be monitored to ensure value for money.

<u>Access schemes</u>

4.5. Access schemes make use of underspend and reclaimed contract value to fund targeted access programmes and interventions. Historically there has been under-delivery against the total contract value due to workforce challenges. Some of this funding was 'clawed back' by NHS England and the remainder used to support access schemes.

4.6. To date funding between November 2022 to March 2023 has covered increasing access for those most in need, including those requiring urgent dental care. The no-fixed abode project in Leeds has also been extended to cover Bradford and Wakefield.

4.7. In 22/23 £1.5m of this funding was used to support additional access schemes in dental practices in areas where need was greatest, seeing around 17,000 patients across 47 practices in West Yorkshire. £0.5m was used to address orthodontics waiting lists.

4.8. In 23/24, it is estimated that there will be around £3.7m-£4.5m of contract under-delivery, over and above the £2m set out above. The 23/24 NHS planning guidance stipulated that dental funding should be ring fenced and not used to address pressures elsewhere in the system.

4.9. By taking a higher risk appetite and planning earlier we believe that this funding could be utilised as follows:

- Community dental services waiting list initiatives – a recent review of community dental services identified extensive waiting lists for children and adults. There is appetite within the three providers in West Yorkshire to engage in a discussion about increasing capacity and making best use of skill mix.
- Secondary care waiting list initiatives – building on the success of the Leeds Teaching Hospitals NHS Trust 'Super Saturday' clinics to reduce waiting lists, seeing between 40 and 70 patients at each Saturday session.

- Further expansion of the access schemes described above.
- Continuation of Golden Hello payments, which would be made available to practices for each eligible new full-time NHS dentist moving into agreed targeted areas. These would be targeted toward practices in areas where there are evidenced gaps in access to dental treatment.
- Primary care waiting list validation to ascertain the true extent of unmet need across West Yorkshire and practice approaches to waiting list management, as well as to support a better understanding of workforce requirements.

4.10 The Board is asked to:

- **Support the approach to extending the current flexible commissioning practices beyond the current scope (in a way that is consistent with the national contract), working with Local Dental Committees and other partners to build on existing good practice.**
- **Committees and other partners to build on existing good practice.**
- **Support the development of further plans to invest the additional £4.5m in the areas identified above.**

5. Workforce

5.1. The recruitment, retention, training, education and development of the whole dental workforce is a key NHSE dental commissioning strategic priority in Y&H.

5.2. The COVID-19 pandemic and Brexit have impacted dental workforce recruitment and retention, affecting Y&H to a greater extent than the rest of England, particularly in areas within the region that rely more heavily on employment of EU dentists.

5.3. Dental workforce planning is essential to secure high quality evidence based dental care pathways, reduce inequalities in access, outcome and patient experience and provide value for money.

5.4. The Health Education England Advancing Dental Care Review sets out the following key principles; better use of the skill mix of the dental workforce and multi-disciplinary team working, co-ordination and distribution of postgraduate training posts so that it is better aligned to areas with the highest levels of oral health inequalities, more flexible training routes, and flexible options for qualified dentists and dental care professionals to increase their knowledge and skills, allowing them greater professional satisfaction and meeting demands for new capabilities and competence, including leadership, management and research.

5.5. Retention is a key issue and simply funding and recruiting more dental graduates is unlikely to address the problem. Our offer to new and existing dentists – how we develop, educate, train and value them – is as important.

5.6. Not improving our offer and “pull” simply means that we will not be able to develop optimal pathways, reduce inequalities, or provide a good quality of care. The

challenges that the public describe could not be addressed.

5.7. There is work ongoing across Y&H that can bring several benefits to our workforce and service delivery, including:

- Primary care dental practice survey
- 'Golden Hello' scheme, which provides financial incentives to aid recruitment and retention in areas of high deprivation
- Performer List Validation by Experience scheme, which supports the recruitment of international dental graduates
- Development opportunities for primary care dental teams and specialist training to allow patients to be treated closer to home.

5.8. We need to be ambitious beyond this to truly transform our workforce offer and service delivery, and develop a workforce plan encapsulating the following:

- A comprehensive survey of the current workforce
- Funding international dental graduate placements in areas of most need
- Developing innovative training models in primary dental care, including adequate training places for dental nurses
- Proactive recruitment and development of current workforce to meet population need
- Establishing centres for development that support flexible dental training pathways and clinical support for different parts of the workforce
- Considering the extension of flexible commissioning (as outlined in section 4.8) and addressing contract limitations (as outlined in section 2.6) as core to the workforce experience.

5.9. The Board is asked to support the development of a West Yorkshire dental workforce plan covering the areas described above.

6. Commissioning Capacity

6.1. The transferred capacity of the dental commissioning team is small. Given the scope of dental challenges and the ambitions we have, we believe this current capacity is insufficient in enabling us to move towards more flexible commissioning models and taking a more integrated approach to oral health and dental services.

6.2. A conservative estimate is that across Y&H there is a shortfall of around 6.5 whole time equivalent posts in the core commissioning team.

6.3. In addition to this, it will be important to have clear connecting points into the five places in WY to provide more structured engagement in each place and ensure that transformation meets local needs.

6.4. **The Board is asked to:**

6.4.1. Support the recruitment of 6.5 WTE additional posts to the commissioning team for Yorkshire and Humber team (recognising that each ICB will need to fund a 1/3 share of this).

6.4.2. Through the ongoing operating model review, support the proposal that each place identifying a named lead to act as the connecting point with the dental commissioning team.

7. Summary of recommendations

7.1. It is recommended that the Board:

- **Support exploration of a collaborative approach with the WY local authorities to the commissioning evidence informed oral health prevention interventions that support a common risk factor and life course approach.**
- **Support the approach to extending the current flexible commissioning practices beyond the current scope (in a way that is consistent with the national contract), working with Local Dental Committees and other partners to build on existing good practice.**
- **Support the development of further plans to invest the additional £4.5m of estimated underspend in the areas identified in the paper.**
- **Support the development of a West Yorkshire dental workforce plan covering the areas described in the paper.**
- **Support the recruitment of 6.5 WTE additional posts to the commissioning team for Yorkshire and Humber team (recognising that each ICB will need to fund a 1/3 share of this).**
- **Through the ongoing operating model review, support the proposal that each place identifying a named lead to act as the connecting point with the dental commissioning team.**

Appendix A **Dental Locality Profile –**

Bradford March 2023

Overview

- Bradford is a unitary authority in West Yorkshire (population 542,128) which in common with the remainder of the region has an **increasing and ageing population**.[1]
- It is an ethnically diverse area, with the largest proportion of people of Pakistani ethnic origin in England.[2]
- Bradford is one of the most deprived local authorities in England and ranks 13th out of 317 Local Authority Districts. Deprivation varies greatly across the District, with wards generally around central Bradford and central Keighley appearing in the 10% most deprived wards in the country and wards located in the Wharfe Valley appearing in the 10% least deprived wards in the country.[2] Deprivation is strongly correlated with experience of dental disease for both children and adults.
- The prevalence of chronic conditions (CVD, diabetes) is higher than the national rates. These conditions share common risk factors (tobacco, and sugar and alcohol consumption) with oral diseases.[3]
- Although rates of smoking and alcohol consumption have reduced in Bradford the long-term effects are reflected in Bradford has a statistically higher incidence and mortality of oral cancer than England.[3,4]

Positives

- Distribution of practices across Bradford is good with practices focussed in areas of population density and includes more deprived areas (see maps).
- Primary care specialist orthodontic and IMOS practices.
- Good local engagement with YH developments (transitional / flexible commissioning, access programme).
- Active local authority led Oral Health Action Group (OHAG) with an oral health plan in place and commissioned evidence informed prevention programmes focussed on children (including improving access to fluoride and reducing sugar consumption) and supported by local research projects.

Challenges

- In Bradford experience of dental decay in 5-year-olds is higher than that in YH and England, with the highest prevalence in the Bradford Moor, City and Toller wards.[5,6]
- **Poor oral health is largely preventable**. Oral disease developed in childhood has lifelong consequences. Access to timely prevention and care needs to adopt a **life course approach** and should include increasing access to fluorides, dietary control of sugars and reducing tobacco and alcohol use.

- There is no simple formula for **estimation of unmet need** in an area. Dental needs can be unmet due to a variety of reasons (waiting lists/volume commissioned, cost, physical access to premises, ability to travel, opening hours/ability to take time off work/caring responsibilities). Most patients would like a relationship/registration with a named practice of the type that exists for general medical services and to access those services as they choose (either regularly or only occasionally or when they have an urgent need). GP practices have patient lists whilst dental practices are contracted to delivery activity. Dental practices are obliged only to deliver a course of treatment to an individual, not ongoing regular care however many practices do tend to see patients regularly.
- **Expectations of retaining some or all dentition for life** will be resource intensive. Maintenance of a heavily restored dentitions is complex potentially requiring specialist skills and often compounded by medical complexity, polypharmacy and the ability to self-care as an individual ages.
- **Access to data** – the local authority are fortunate in that they are currently able to commission epidemiology fieldwork for the national dental epidemiology programme from a local provider. It is essential that epidemiological surveys continue to be commissioned to enable identification of oral health inequalities.
- **Access to dental care** is the commonest reason for calls to HealthWatch across the region. Access rates for both adults and children in Bradford are lower than the national rates.
- UDAs commissioned per capita in Bradford are lower than WY ICB and YH
- Delivery of commissioned UDAs (more than 87% in 2019/20).

Current workstreams

- Review of YH **Community Dental Services** which has led to focussed work on recovery of dental GA services, workforce development (including level 2) and development of dental sedation services.
- NHSE YH accreditation of **level 2 paediatric practitioners** from the 1st cohort of the 2yr training programme developed by HEE YH. 3rd training cohort currently being recruited.
- **Level 2 Special Care** Dentistry training programme has also been developed and the 1st cohort are being recruited.
- **Transformational commissioning** – review and further development / merging of flexible commissioning and access programmes focussed on need and addressing inequalities.
- **Waiting list validation** – seeking to understand how practices record and manage waiting lists.
- **Domiciliary care –** access to dental care for those patients who are for housebound and unable to access local dental practices.
- **Homeless –** sessional model in dental practices piloted in Leeds to be rolled out to other targeted areas of YH including Bradford.

In the future we need to consider….

- **Access to prevention** interventions for all ages (life course), including expansion of delivery of prevention focussed practices (transformational/flexible commissioning)
- Patient facing **communications** – NHS dentistry how and when to access, recall intervals based on need (NICE guidance)
- Development of pathways that meet the **needs of an ageing population** - not just domiciliary services. Integration of pathways with the wider system (eg. post diagnosis), development of the dental team (level 2 SCD etc), estate/physical access.
- **Investment** – focussed on need and addressing inequalities. The OHNA assessment and commissioning data leads to the identification of the following areas:

Reallocation of resources to existing practices (within year / small numbers of UDAs)	
Wards with the highest level of deprivation (IMD 1) in the first instance.	City (Bradford Eccleshill Keighley Central Keighley West Little Horton Tong
Commissioning in a new location/recommissioning in an existing location/retaining an existing practice	
IMD 1 – no GDS services commissioned	Royds
IMD 1 - GDS services commissioned per head of population low	Clayton and Fairweather Green Eccleshill Keighley West

Investment decisions should also consider:

- Population distribution – see maps.
- Accessibility / transport links
- Contract delivery – poorer delivery may have underlying factors that investment may mitigate, for example opportunities for career/practice development/specialisation
- Contemporary intelligence from key local stakeholders

Population and their oral health needs

	Bradford	WY ICB	Yorkshire & the Humber	England
Population[1]	542,128			
Predicted change in population (2020-2040) -All ages	6%	6%	6%	
0-19 years of age	-6%	-1%	-2%	
20-64 years of age	0%	1%	0%	
65+ years of age	37%	34%	33%	
85+ years of age	57%	63%	66%	
Epidemiology				
5-year-olds (2019)[5,6]				
% with experience of decay	36.0%	N/A	28.7%	23.4%
Mean number of teeth affected in those with decay (mean dmft (dmft>0))	4.3	N/A	3.8	3.4
% with sepsis	2.1%	N/A	1.4%	1%
Mildly dependant older (2016)[8]				
Edentulous (no teeth)	14.8%	N/A	32.4%	27%
Of those with teeth - reporting pain in mouth	13.0%	N/A	9.7%	9.5%
% evidence of infection/sepsis	0%	N/A	10.7%	7.8%
Oral cancer[4] Standardised rate per 100,000				
Incidence - lip, oral cavity and pharynx (C00-C14)	17.28	N/A	15.26	14.55
Incidence - oral cavity (C00- C06)	10.39	N/A	8.7	8.36
Mortality - lip, oral cavity and pharynx (C00-C14)	6.11	N/A	4.7	4.54
Mortality - oral cavity (C00- C06)	3.03	N/A	2.18	2.19

Red - worse than YH and England; **Amber** -worse than YH but better than England; **Green** – better than YH and England

Commissioned dental services

	Bradford	WY ICB	YH	England
Primary Care Services				
Numbers of GDS providers	51	265	611	
Wards in Bradford with an NHS dental practice	24 wards. 11 - IMD decile 1- (most deprived)			
Wards without an NHS dental practice in Bradford	Royds (IMD 1); Keighley East (IMD 3); Worth Valley (IMD 6); Wharfedale (IMD 10)			
UDAs commissioned (2019-20)	796,772	3,827,464	8,665,024	
UDAs delivered (2019-20)	692,383	3,489,016	8,003,442	
Total value of commissioned UDAs	£24,942,873	£120,585,967.51	£285,954,684.20	
UDAs commissioned per capita	1.47	1.59	1.6	
Specialist primary care services				
Orthodontic providers	12 - (Bradford Airedale 3; Bradford City 3; Bradford North 3; Bradford South 3)	31	75	
IMOS providers	2	8	19	
CDS providers	1 (Bradford Community Healthcare Trust)	4	9	
Dental Access[8]				
Adult *(% pop^{n} in 24 months to 30th June '22)*	36.8%		41.8% (NHS NEY)	37.4%
Child *(% pop^{n} in 12 months to 30th June '22)*	46.3%		48.9% (NHS NEY)	46.9%
Oral Health Prevention				
Fluoride varnish - (0-17yrs)[9] - *FP17 forms (Nov 2021-Oct 2022*	57.4%	56%	59.5%	54.6%
Innovation in primary care				
Flexible commissioning practices	15	56	152	
Practices in Access scheme	6	29	55	
Practices providing additional urgent access sessions (to end March 2023)	9	47	106	
Practice locations prioritised under 'Golden Hello' scheme (IMD 1)	2	27	120	

Red - worse than YH and England; **Amber** -worse than YH but better than England; **Green** – better than YH and England

Figure 1: NHS GDS providers in Bradford superimposed on deprivation (IMD, 2019) (darker = more deprived).

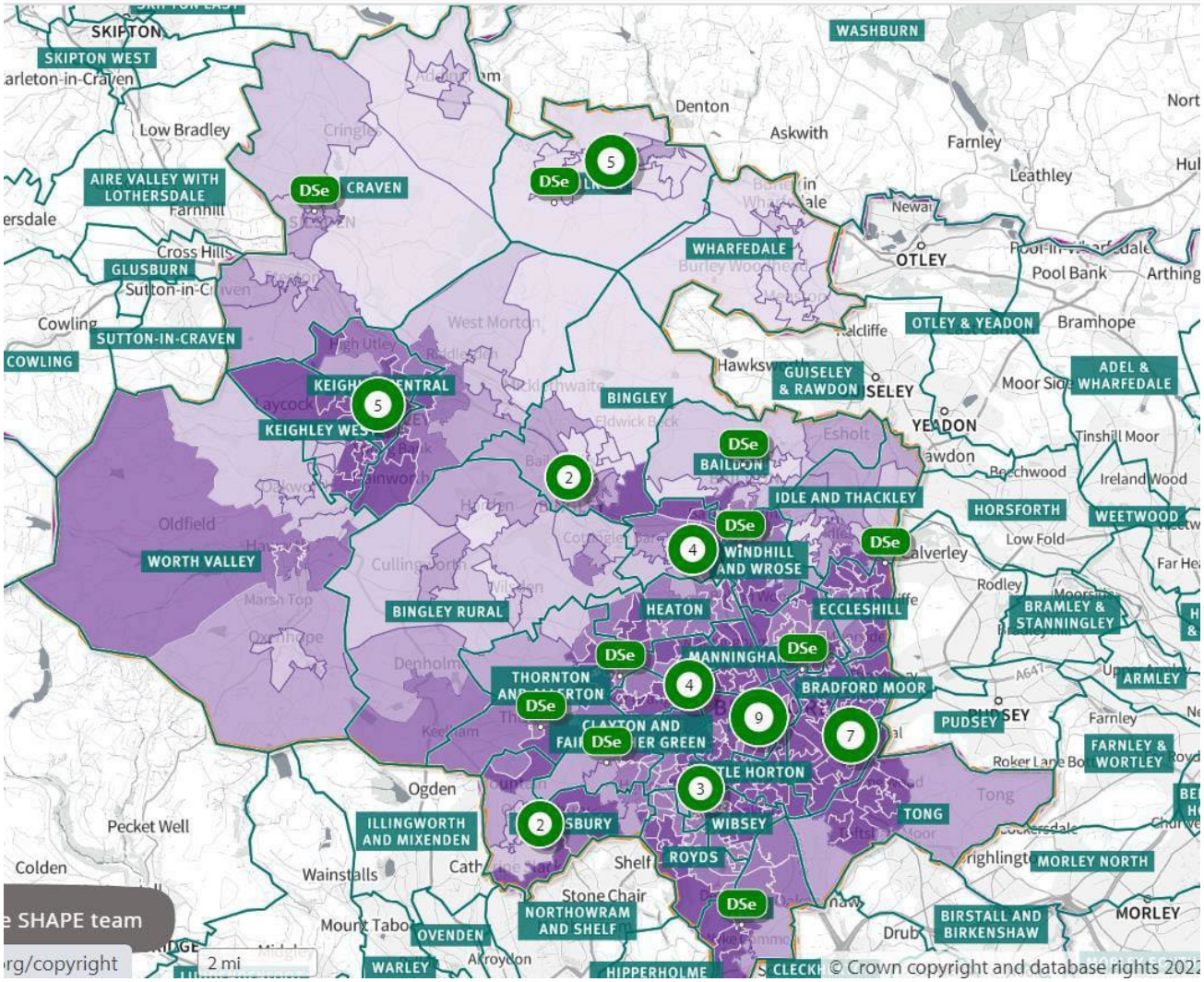
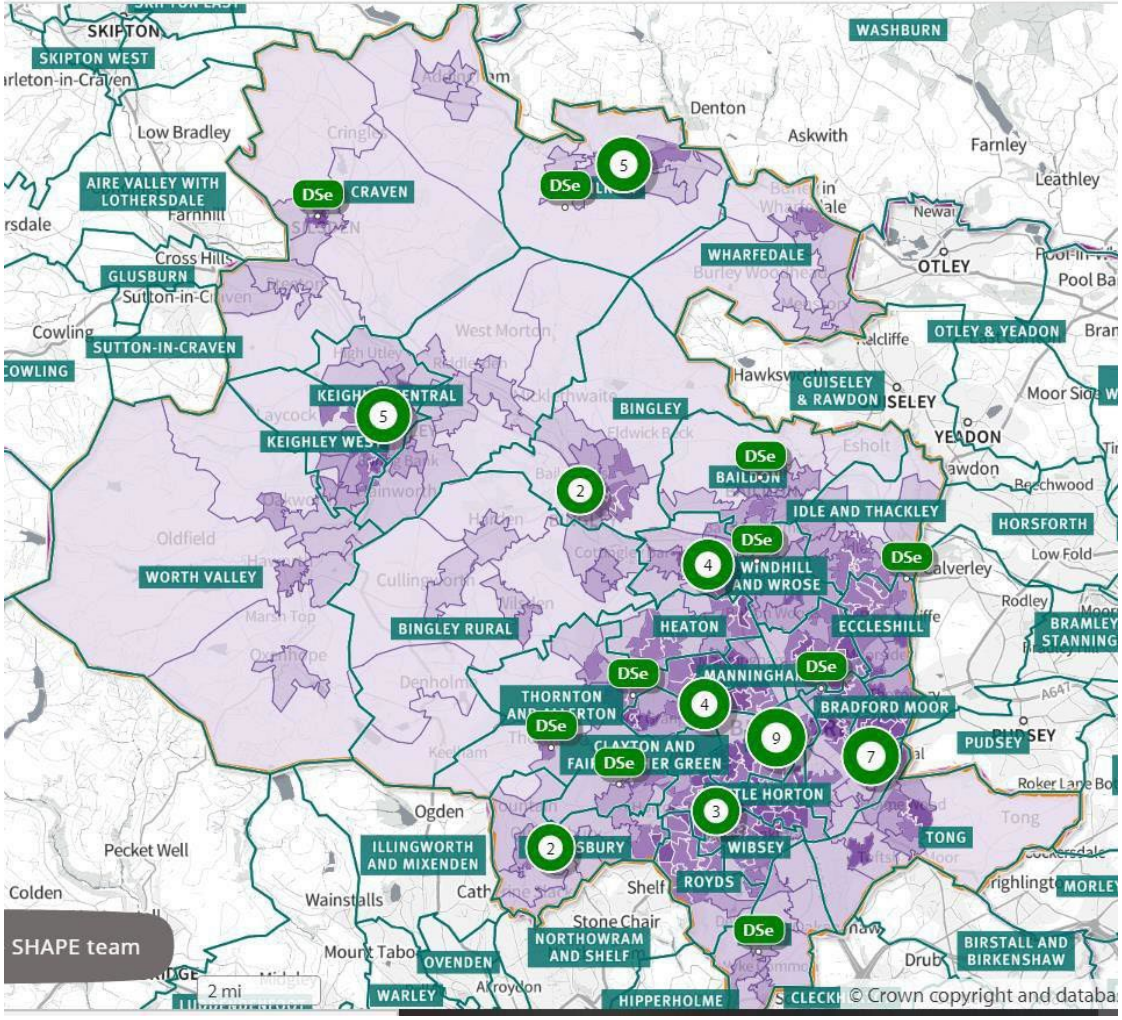


Figure 2: NHS GDS providers superimposed on population density (mid-2020) for Bradford (darker = greater population density) with mapped (source NHSBSA)



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8. Access data; Annex 2; Table 1 (e and f). NHS BSA https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental- statistics/2021-22-annual-report
9. Fluoride varnish data download. NHS BSA, November 2022.

Dental Locality Profile –

Calderdale March 2023

Overview

- Calderdale is a unitary authority in West Yorkshire (population 211,439) which in common with the remainder of the region has an **increasing and ageing population**.[1]
- There is a relatively small ethnic minority population.[1]
- Calderdale is ranked 66th most deprived local authority out of 317 in England. 10 areas in the Borough are within the 10% most deprived in the country. [2] Deprivation is strongly correlated with experience of dental disease for both children and adults.
- The prevalence of chronic conditions (CVD, diabetes) is higher than the national rates. These conditions share common risk factors (tobacco, and sugar and alcohol consumption) with oral diseases[3].

Positives

- Distribution of practices across Calderdale is good with practices focussed in areas of population density and includes more deprived areas (see maps).
- Compared to England, access rates for children in Calderdale are higher and those for adults are similar to the national rates.
- UDAs commissioned per capita in Calderdale is higher than WY ICB and YH.
- Primary care specialist orthodontic practices.
- Some local engagement with YH developments (transitional / flexible commissioning, access programme).
- There is a jointly led local authority Oral Health Action Group (OHAG) with Kirklees. The local authority commission evidence informed prevention programmes focussed on children.

Challenges

- In Calderdale experience of dental decay in 5-year-olds is better than YH but worse than England. Within Calderdale the highest experience of decay is clustered around the Central and North localities.[5,6]
- **Poor oral health is largely preventable**. Oral disease developed in childhood has lifelong consequences. Access to timely prevention and care needs to adopt a **life course approach** and should include increasing access to fluorides, dietary control of sugars and reducing tobacco and alcohol use.
- **Access to dental care** is the commonest reason for calls to Health Watch across the region. Although per capita commissioning of UDAs is higher in Calderdale that WY and YH, only 88% of commissioned activity is delivered.
- There is no simple formula for **estimation of unmet need** in an area. Dental needs can be unmet due to a variety of reasons (waiting lists/volume commissioned, cost, physical access to premises, ability to travel, opening hours/ability to take time off work/caring responsibilities). Most patients would like a

relationship/registration with a named practice of the type that exists for general medical services and to access those services as they choose (either regularly or only occasionally or when they have an urgent need). GP practices have patient lists whilst dental practices are contracted to delivery activity. Dental practices are obliged only to deliver a course of treatment to an individual, not ongoing regular care however many practices do tend to see patients regularly.

- **Expectations of retaining some or all dentition for life** will be resource intensive. Maintenance of a heavily restored dentitions is complex potentially requiring specialist skills and often compounded by medical complexity, polypharmacy and the ability to self-care as an individual ages.
- **Access to data** – the local authority has the commissioning responsibility for the epidemiology fieldwork but are currently unable to secure a provider. There will be no further updates to the data currently reported in the oral health needs assessment unless this situation is addressed as a priority. It is essential that epidemiological surveys continue to be commissioned to enable identification of oral health inequalities.

Current workstreams

- Review of YH **Community Dental Services** which has led to focussed work on recovery of dental GA services, workforce development (including level 2) and development of dental sedation services.
- NHSE YH accreditation of **level 2 paediatric practitioners** from the 1st cohort of the 2yr training programme developed by HEE YH. 3rd training cohort currently being recruited.
- **Level 2 Special Care** Dentistry training programme has also been developed and the 1st cohort are being recruited.
- **Transformational commissioning** – review and further development / merging of flexible commissioning and access programmes focussed on need and addressing inequalities.
- **Waiting list validation** – seeking to understand how practices record and manage waiting lists.
- **Domiciliary care –** access to dental care for those patients who are for housebound and unable to access local dental practices.

In the future we need to consider….

- **Access to prevention** interventions for all ages (life course), including expansion of delivery of prevention focussed practices (transformational/flexible commissioning)
- Patient facing **communications** – NHS dentistry how and when to access, recall intervals based on need (NICE guidance)
- Development of pathways that meet the **needs of an ageing population** - not just domiciliary services. Integration of pathways with the wider system (eg. post diagnosis), development of the dental team (level 2 SCD etc), estate/physical access.
- **Investment** – focussed on need and addressing inequalities. The OHNA assessment and commissioning data leads to the identification of the following areas:

Reallocation of resources to existing practices (within year / small numbers of UDAs)	
Wards with the highest level of deprivation (IMD 1) in the first instance.	Ovendon (IMD 1) Illingworth and Mixenden (IMD 2) Todmorden (IMD 2) Warley (IMD 2) Elland (IMD 3) Calder (IMD 4)
Commissioning in a new location/recommissioning in an existing location/retaining an existing practice	
IMD 4 - no GDS services commissioned	Park
IMD 2 – GDS services commissioned	Illingworth and Mixenden Warley

Investment decisions should also consider:

- Population distribution – see maps.
- Accessibility / transport links
- Contract delivery – poorer delivery may have underlying factors that investment may mitigate, for example opportunities for career/practice development/specialisation
- Contemporary intelligence from key local stakeholders

Population and their oral health needs

	Calderdale	WY ICB	Yorkshire & the Humber	England
Population[1]	211,439			
Predicted change in population (2020-2040) -All ages	3%	6%	6%	
0-19 years of age	-8%	-1%	-2%	
20-64 years of age	-4%	1%	0%	
65+ years of age	36%	34%	33%	
85+ years of age	72%	63%	66%	
Epidemiology				
5-year-olds (2019)[4,5]				
% with experience of decay	26.7%	N/A	28.7%	23.4%
Mean number of teeth affected in those with decay (mean dmft (dmft>0))	4.1	N/A	3.8	3.4
% with sepsis	0.3%	N/A	1.4%	1%
Mildly dependant older (2016)[6]				
Edentulous (no teeth)	24.2%	N/A	32.4%	27%
Of those with teeth - reporting pain in mouth	12%	N/A	9.7%	9.5%
% evidence of infection/sepsis	4%	N/A	10.7%	7.8%
Oral cancer[7] Standardised rate per 100,000				
Incidence - lip, oral cavity and pharynx (C00-C14)	14.45	N/A	15.26	14.55
Incidence - oral cavity (C00- C06)	8.54	N/A	8.7	8.36
Mortality - lip, oral cavity and pharynx (C00-C14)	3.69	N/A	4.7	4.54
Mortality - oral cavity (C00- C06)	2.03	N/A	2.18	2.19

Red - worse than YH and England; **Amber** - better than YH but worse than England; **Green** – better than YH and England

Commissioned dental services

	Calderdale	WY ICB	YH	England
Primary Care Services				
Numbers of GDS providers	24	265	611	
Wards in Calderdale with an NHS dental practice	16 wards. 11 IMD deciles 1-3 (most deprived)			
Wards without an NHS dental practice in Calderdale	Park			
UDAs commissioned (2019-20)	388,009	3,827,464	8,665,024	
UDAs delivered (2019-20)	339,764	3,489,016	8,003,442	
Total value of commissioned UDAs	£11,876,080	£120,585,967.51	£285,954,684.20	
UDAs commissioned per capita	1.84	1.59	1.6	
Specialist primary care services				
Orthodontic providers	2	31	75	
IMOS providers	0	8	19	
CDS providers	1 (Locala CIC)	4	9	
Dental Access[8]				
Adult *(% popⁿ in 24 months to 30th June '22)*	42.5%		41.8% (NHS NEY)	37.4%
Child *(% popⁿ in 12 months to 30th June '22)*	53.2%		48.9% (NHS NEY)	46.9%
Oral Health Prevention				
Fluoride varnish - (0-17yrs)[9] - *FP17 forms (Nov 2021-Oct 2022*	54.1%	56%	59.5%	54.6%
Innovation in primary care				
Flexible commissioning practices	1	56	152	
Practices in Access scheme	4	29	55	
Practices providing additional urgent access sessions (to end March 2023)	2	47	106	
Practice locations prioritised under 'Golden Hello' scheme (IMD 1)	3	27	120	

Red - worse than YH and England; **Amber** -worse than YH but better than England; **Green** – better than YH and England

Figure 1: NHS GDS providers in Calderdale superimposed on deprivation (IMD, 2019) (darker = more deprived).

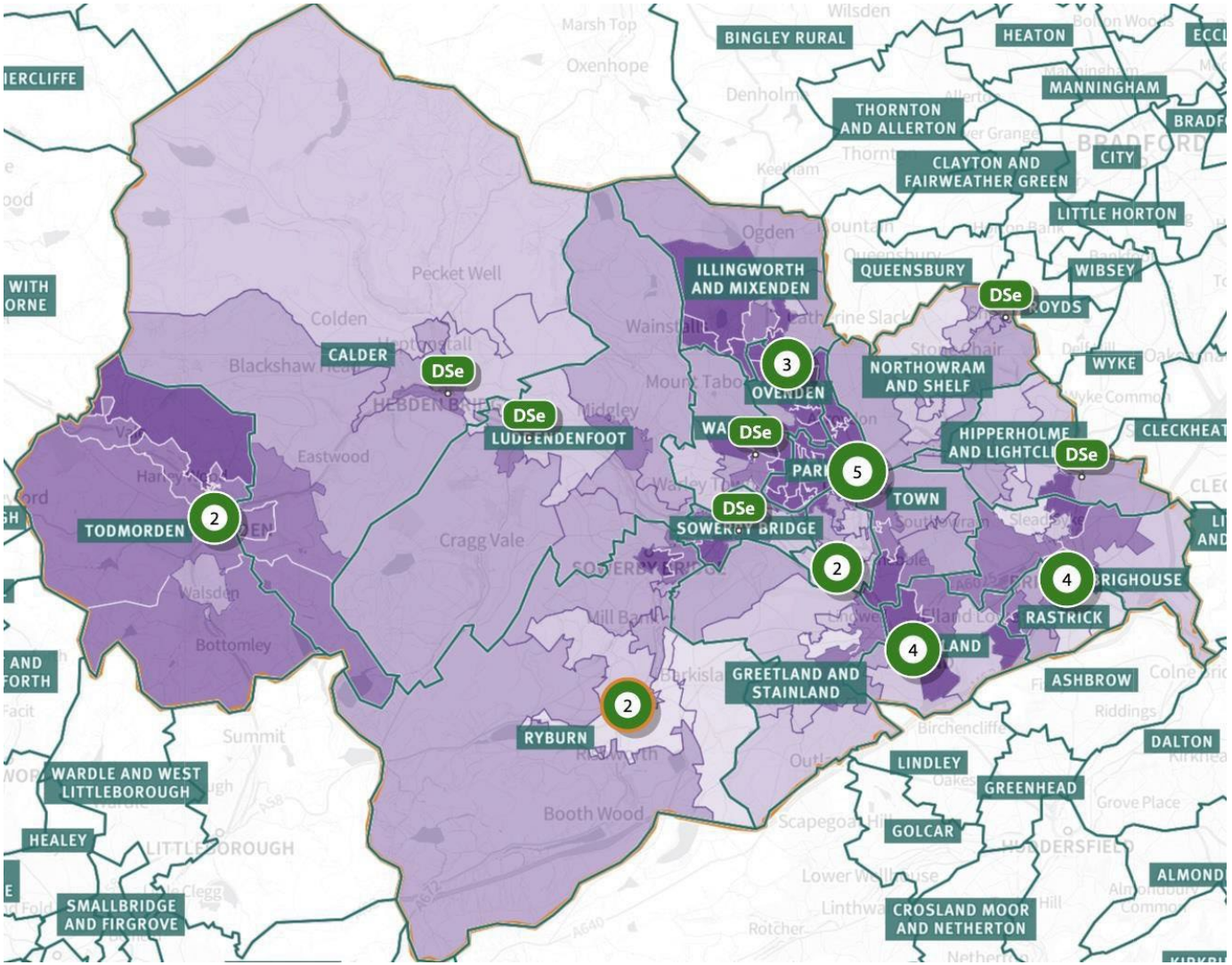
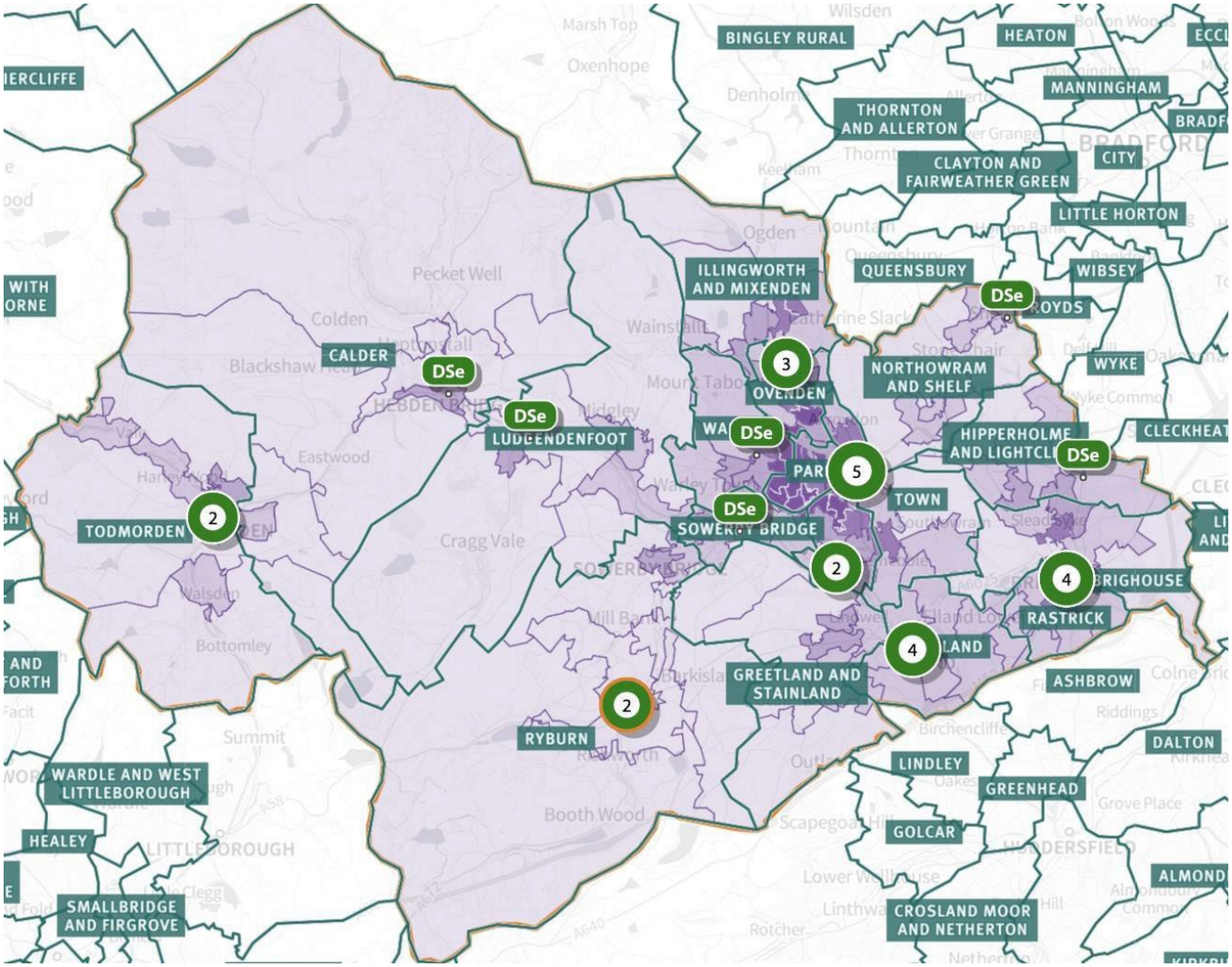


Figure 2: NHS GDS providers superimposed on population density (mid-2020) for Calderdale (darker = greater population density) with mapped (source NHSBSA)



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9. Fluoride varnish data download. NHS BSA, November 2022.

Dental Locality Profile – Kirklees

13.03.23

Overview

- Kirklees is a unitary authority in West Yorkshire (population 441,290) which in common with the remainder of the region has an **increasing and ageing population**.[1]
- There is small ethnic minority population.[1] Asylum seekers and European economic migrants are contributing to the emergence of new communities within Kirklees.[2]
- Kirklees has a higher proportion of highly deprived LSOAs compared to the national average.[2] Deprivation is strongly correlated with experience of dental disease for both children and adults.
- The prevalence of chronic conditions (CVD, diabetes) is higher than the national rates. These conditions share common risk factors (tobacco, and sugar and alcohol consumption) with oral diseases[3].

Positives

- Distribution of practices across Kirklees is good with practices focussed in areas of population density and includes more deprived areas (see maps).
- Access rates for both adults and children in Kirklees are higher than the national rates.
- UDAs commissioned per capita in Kirklees is higher than WY ICB and YH
- High delivery of commissioned UDAs (more than 95% in 2019/20).
- Primary care specialist orthodontic and IMOS practices.
- Some local engagement with YH developments (transitional / flexible commissioning, access programme).
- There is a jointly led local authority Oral Health Action Group (OHAG) with Calderdale.

Challenges

- Experience of dental decay in five-year-olds in Kirklees is higher than that found regionally and nationally. Within Kirklees, the greatest of decay are clustered in the Dewsbury & Thornhill and Greenwood Primary Care Networks [4,5].
- **Poor oral health is largely preventable**. Oral disease developed in childhood has lifelong consequences. Access to timely prevention and care needs to adopt a **life course approach** and should include increasing access to fluorides, dietary control of sugars and reducing tobacco and alcohol use.
- There is no simple formula for **estimation of unmet need** in an area. Dental needs can be unmet due to a variety of reasons (waiting lists/volume commissioned, cost, physical access to premises, ability to travel, opening hours/ability to take time off work/caring responsibilities). Most patients would like a

relationship/registration with a named practice of the type that exists for general medical services and to access those services as they choose (either regularly or only occasionally or when they have an urgent need). GP practices have patient lists whilst dental practices are contracted to delivery activity. Dental practices are obliged only to deliver a course of treatment to an individual, not ongoing regular care however many practices do tend to see patients regularly.

- **Expectations of retaining some or all dentition for life** will be resource intensive. Maintenance of a heavily restored dentitions is complex potentially requiring specialist skills and often compounded by medical complexity, polypharmacy and the ability to self-care as an individual ages.
- **Access to data** – the local authority has the commissioning responsibility for the epidemiology fieldwork but are currently unable to secure a provider. There will be no further updates to the data currently reported in the oral health needs assessment unless this situation is addressed as a priority. It is essential that epidemiological surveys continue to be commissioned to enable identification of oral health inequalities.
- **Access to dental care** is the commonest reason for calls to Health Watch across the region.

Current workstreams

- Review of YH **Community Dental Services** which has led to focussed work on recovery of dental GA services, workforce development (including level 2) and development of dental sedation services.
- NHSE YH accreditation of **level 2 paediatric practitioners** from the 1st cohort of the 2yr training programme developed by HEE YH. 3rd training cohort currently being recruited.
- **Level 2 Special Care** Dentistry training programme has also been developed and the 1st cohort are being recruited.
- **Transformational commissioning** – review and further development / merging of flexible commissioning and access programmes focussed on need and addressing inequalities.
- **Waiting list validation** – seeking to understand how practices record and manage waiting lists.
- **Domiciliary care –** access to dental care for those patients who are for housebound and unable to access local dental practices.

In the future we need to consider….

- **Access to prevention** interventions for all ages (life course), including expansion of delivery of prevention focussed practices (transformational/flexible commissioning)
- Patient facing **communications** – NHS dentistry how and when to access, recall intervals based on need (NICE guidance)
- Development of pathways that meet the **needs of an ageing population** - not just domiciliary services. Integration of pathways with the wider system (eg. post diagnosis), development of the dental team (level 2 SCD etc), estate/physical access.
- **Investment** – focussed on need and addressing inequalities. The OHNA assessment and commissioning data leads to the identification of the following areas:

Reallocation of resources to existing practices (within year / small numbers of UDAs)	
Wards with the highest level of deprivation (IMD 1) in the first instance.	Ashbrow Crosland Moor and Netherton Dewsbury South Dalton Greenhead
Commissioning in a new location/recommissioning in an existing location/retaining an existing practice	
IMD 1-3 - No GDS services commissioned	Dewsbury West (IMD 1) Batley West (IMD 2) Liversedge and Gomersal (IMD 3)
IMD 2 – GDS services commissioned	Ashbrow Crosland Moor and Netherton Dewsbury South Dalton Greenhead

Investment decisions should also consider:

- Population distribution – see maps.
- Accessibility / transport links
- Contract delivery – poorer delivery may have underlying factors that investment may mitigate, for example opportunities for career/practice development/specialisation
- Contemporary intelligence from key local stakeholders

Population and their oral health needs

	Kirklees	WY ICB	Yorkshire & the Humber	England
Population[1]	441,290			
Predicted change in population (2020-2040) -All ages	4%	6%	6%	
0-19 years of age	-5%	-1%	-2%	
20-64 years of age	-1%	1%	0%	
65+ years of age	34%	34%	33%	
85+ years of age	75%	63%	66%	
Epidemiology				
5-year-olds (2019)[4,5]				
% with experience of decay	31.2%	N/A	28.7%	23.4%
Mean number of teeth affected in those with decay (mean dmft (dmft>0))	4.1	N/A	3.8	3.4
% with sepsis	2.0%	N/A	1.4%	1%
Mildly dependant older (2016)[6]				
Edentulous (no teeth)	*	N/A	32.4%	27%
Of those with teeth - reporting pain in mouth	*	N/A	9.7%	9.5%
% evidence of infection/sepsis	*	N/A	10.7%	7.8%
Oral cancer[7] Standardised rate per 100,000				
Incidence - lip, oral cavity and pharynx (C00-C14)	15.31	N/A	15.26	14.55
Incidence - oral cavity (C00- C06)	9.18	N/A	8.7	8.36
Mortality - lip, oral cavity and pharynx (C00-C14)	5.24	N/A	4.7	4.54
Mortality - oral cavity (C00- C06)	2.83	N/A	2.18	2.19
*Numbers examined too small to provide results				

Red - worse than YH and England; **Amber** -worse than YH but better than England; **Green** – better than YH and England

Commissioned dental services

	Kirklees	WY ICB	YH	England
Primary Care Services				
Numbers of GDS providers	50	265	611	
Wards in Kirklees with an NHS dental practice	19 wards. 13 - IMD decile 1-3- (most deprived)			
Wards without an NHS dental practice in Kirklees	Dewsbury West (IMD 1) Batley West (IMD 2) Liversedge and Gomersal (IMD 3)			
UDAs commissioned (2019-20)	750,735	3,827,464	8,665,024	
UDAs delivered (2019-20)	743,983	3,489,016	8,003,442	
Total value of commissioned UDAs	£24,445,234	£120,585,967.51	£285,954,684.20	
UDAs commissioned per capita	1.70	1.59	1.6	
Specialist primary care services				
Orthodontic providers	4 -(Huddersfield 2; Dewsbury and Batley 2)	31	75	
IMOS providers	2	8	19	
CDS providers	1 (Locala CIC)	4	9	
Dental Access[8]				
Adult *(% popⁿ in 24 months to 30th June '22)*	51.6%		41.8% (NHS NEY)	37.4%
Child *(% popⁿ in 12 months to 30th June '22)*	54.7%		48.9% (NHS NEY)	46.9%
Oral Health Prevention				
Fluoride varnish - (0-17yrs)[9] - *FP17 forms (Nov 2021-Oct 2022*	54.2%	56%	59.5%	54.6%
Innovation in primary care				
Flexible commissioning practices	8	56	152	
Practices in Access scheme	7	29	55	
Practices providing additional urgent access sessions (to end March 2023)	8	47	106	
Practice locations prioritised under 'Golden Hello' scheme (IMD 1)	1	27	120	

Red - worse than YH and England; **Amber** -worse than YH but better than England; **Green** – better than YH and England

Figure 1: NHS GDS providers in Kirklees superimposed on deprivation (IMD, 2019) (darker = more deprived).

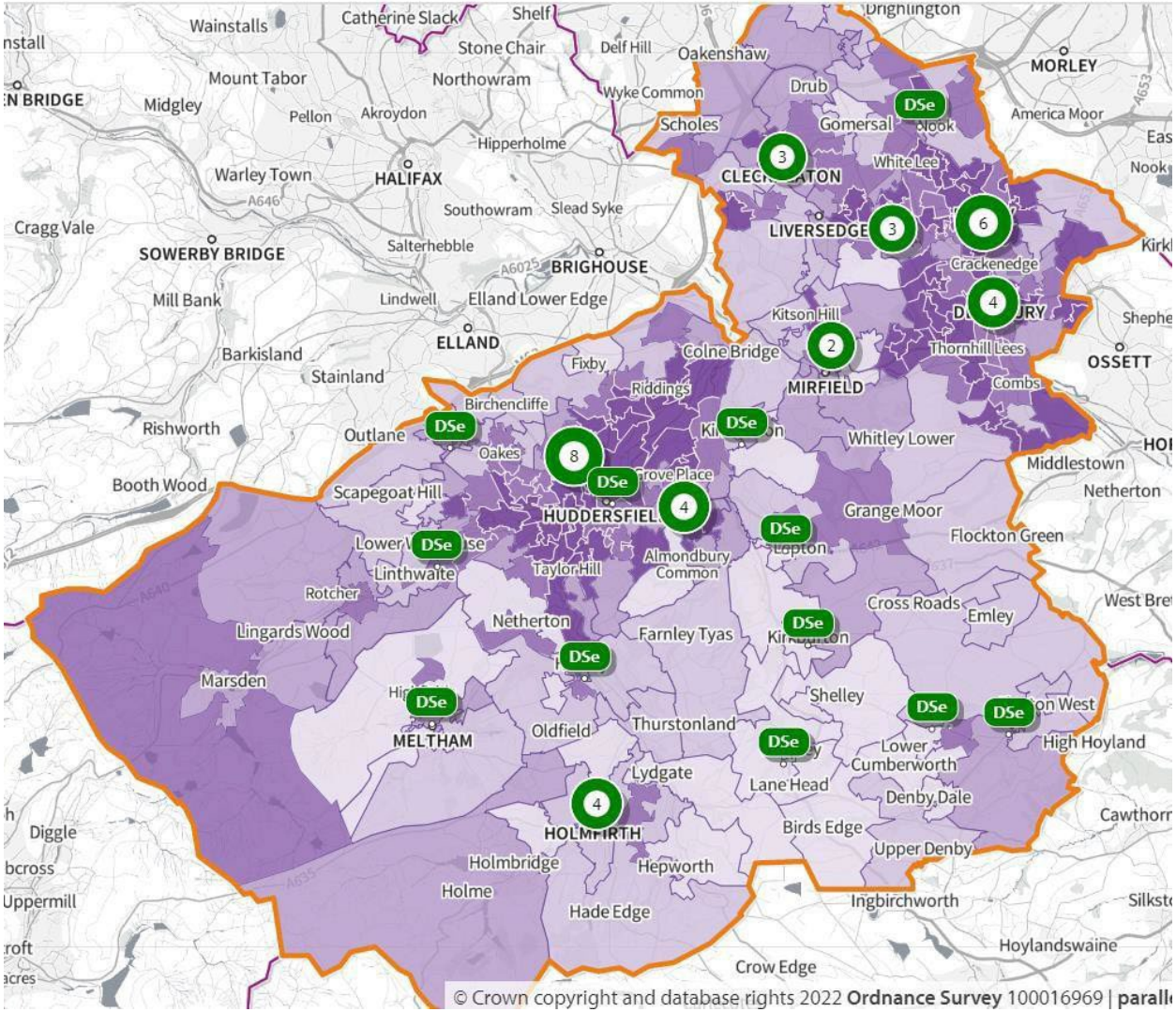
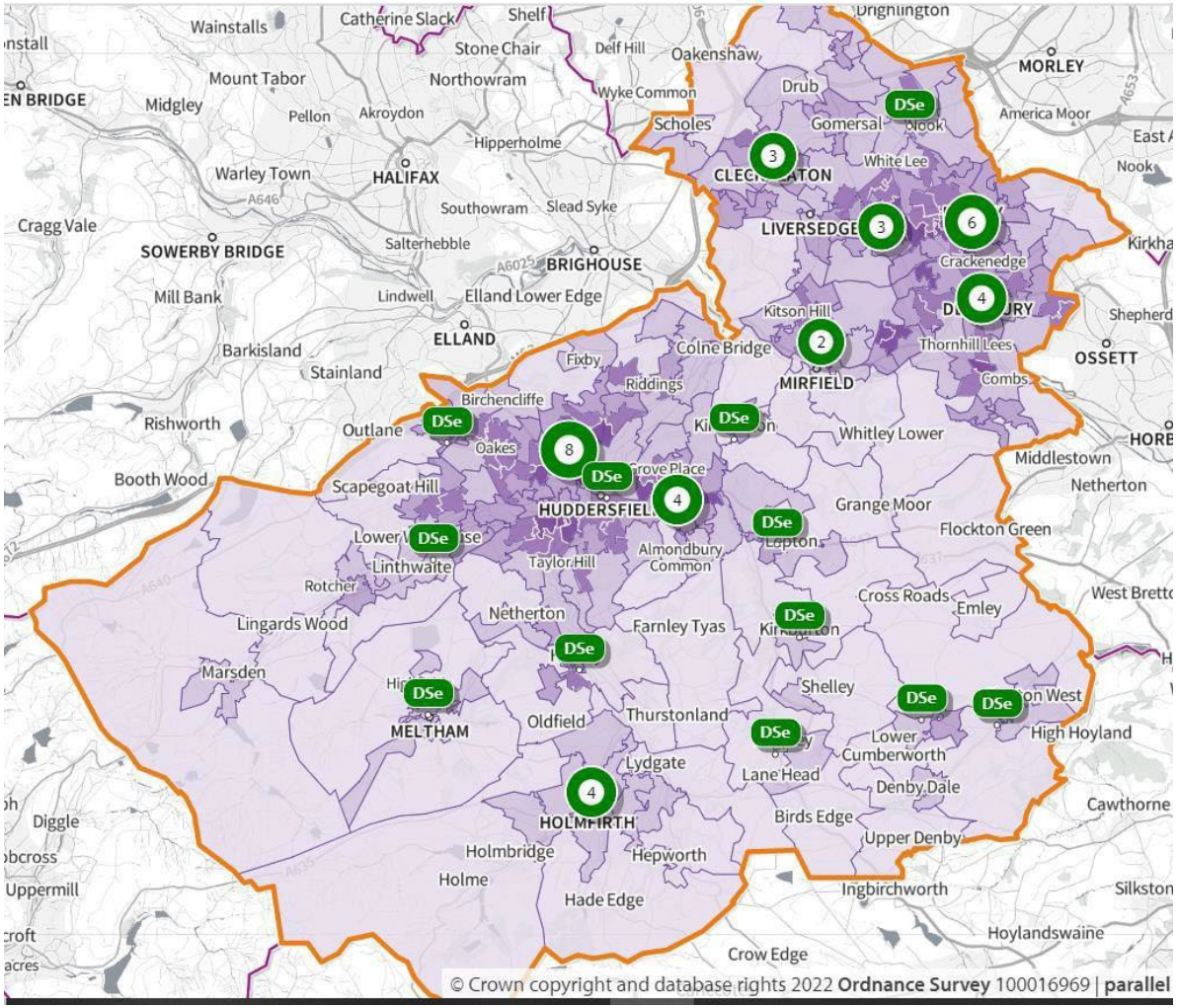


Figure 2: NHS GDS providers superimposed on population density (mid-2020) for Kirklees (darker = greater population density) with mapped (source NHSBSA)



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Dental Locality Profile – Leeds

March 2023

Overview

- Leeds is a unitary authority in West Yorkshire (population 798,796) which in common with the remainder of the region has an **increasing and ageing population**.[1]
- Leeds is an ethnically diverse area.[2]
- Leeds ranks 33 out of 317 local authorities on the proportion of LSOAs in the most deprived 10% nationally [2]. Deprivation is strongly correlated with experience of dental disease for both children and adults.
- The prevalence of chronic conditions (CVD, diabetes) is higher than the national rates. These conditions share common risk factors (tobacco, and sugar and alcohol consumption) with oral diseases[3].
- Although rates of smoking and alcohol consumption have reduced in Leeds the long- term effects are reflected in higher rates of incidence of oral cancer[4].

Positives

- Distribution of practices across Leeds is good with practices focussed in areas of population density and includes more deprived areas (see maps).
- Compared to England, access rates for children in Leeds are higher and those for adults are similar to the national rates.
- Primary care specialist orthodontic and IMOS practices.
- Good local engagement with YH developments (transitional / flexible commissioning, access programme).
- Active local authority led Oral Health Strategy Group with an oral health plan in place and commissioned evidence informed prevention programmes focussed on children (including improving access to fluoride and reducing sugar consumption) and focussed work on access to dental assessment and care for looked after children..
- Sessional model providing dental care for the homeless population successfully piloted in in two Leeds dental practices and recently commissioned. The model will also be rolled out to other targeted areas of YH.

Challenges

- In Leeds experience of dental decay in 5-year-olds is better than YH but worse than England. Within Leeds, the highest is found in the Burmantofts and Richmond Hill, Temple Newsam, Killingbeck and Seacroft wards.[5,6]
- **Poor oral health is largely preventable**. Oral disease developed in childhood has lifelong consequences. Access to timely prevention and care needs to adopt a **life course approach** and should include increasing access to fluorides, dietary control of sugars and reducing tobacco and alcohol use.
- **Access to dental care** is the commonest reason for calls to Healthwatch across the region. UDAs commissioned per capita in Leeds is lower than WY ICB and YH and only 88% of

commissioned activity is delivered.

- There is no simple formula for **estimation of unmet need** in an area. Dental needs can be unmet due to a variety of reasons (waiting lists/volume commissioned, cost, physical access to premises, ability to travel, opening hours/ability to take time off work/caring responsibilities). Most patients would like a relationship/registration with a named practice of the type that exists for general medical services and to access those services as they choose (either regularly or only occasionally or when they have an urgent need). GP practices have patient lists whilst dental practices are contracted to delivery activity. Dental practices are obliged only to deliver a course of treatment to an individual, not ongoing regular care however many practices do tend to see patients regularly.
- **Expectations of retaining some or all dentition for life** will be resource intensive. Maintenance of a heavily restored dentitions is complex potentially requiring specialist skills and often compounded by medical complexity, polypharmacy and the ability to self-care as an individual ages.
- **Access to data** – the local authority has the commissioning responsibility for the epidemiology fieldwork but has recently lost their provider. There will be no further updates to the data currently reported in the oral health needs assessment unless this situation is addressed as a priority. It is essential that epidemiological surveys continue to be commissioned to enable identification of oral health inequalities.

Current workstreams

- Review of YH **Community Dental Services** which has led to focussed work on recovery of dental GA services, workforce development (including level 2) and development of dental sedation services.
- NHSE YH accreditation of **level 2 paediatric practitioners** from the 1st cohort of the 2yr training programme developed by HEE YH. 3rd training cohort currently being recruited.
- **Level 2 Special Care** Dentistry training programme has also been developed and the 1st cohort are being recruited.
- **Transformational commissioning** – review and further development / merging of flexible commissioning and access programmes focussed on need and addressing inequalities.
- **Waiting list validation** – seeking to understand how practices record and manage waiting lists.
- **Domiciliary care –** access to dental care for those patients who are for housebound and unable to access local dental practices.

In the future we need to consider….

- **Access to prevention** interventions for all ages (life course), including expansion of delivery of prevention focussed practices (transformational/flexible commissioning)
- Patient facing **communications** – NHS dentistry how and when to access, recall intervals based on need (NICE guidance)
- Development of pathways that meet the **needs of an ageing population** - not just domiciliary services. Integration of pathways with the wider system (eg. post diagnosis),

development of the dental team (level 2 SCD etc), estate/physical access.

- **Investment** – focussed on need and addressing inequalities. The OHNA assessment and commissioning data leads to the identification of the following areas:

Reallocation of resources to existing practices (within year / small numbers of UDAs)	
Wards with the highest level of deprivation (IMD 1) in the first instance.	Bramley & Stanningley Farnley & Wortley Beeston & Holbeck Middleton Park Killingbeck & Seacroft Burmantofts and Richmond Hill Hunslet and Riverside
Commissioning in a new location/recommissioning in an existing location/retaining an existing practice	
IMD 2 - no GDS services commissioned	Little London & Woodhouse
IMD 1 – GDS services commissioned	Bramley & Stanningley

Investment decisions should also consider:

- Population distribution – see maps.
- Accessibility / transport links
- Contract delivery – poorer delivery may have underlying factors that investment may mitigate, for example opportunities for career/practice development/specialisation
- Contemporary intelligence from key local stakeholders

Population and their oral health needs

	Leeds	WY ICB	Yorkshire & the Humber	England
Population[1]	798,786			
Predicted change in population (2020-2040) -All ages	5%	6%	6%	
0-19 years of age	3%	-1%	-2%	
20-64 years of age	1%	1%	0%	
65+ years of age	24%	34%	33%	
85+ years of age	48%	63%	66%	
Epidemiology				
5-year-olds (2019)[5,6]				
% with experience of decay	26.0%	N/A	28.7%	23.4%
Mean number of teeth affected in those with decay (mean dmft (dmft>0))	3.8	N/A	3.8	3.4
% with sepsis	0.5%	N/A	1.4%	1%
Mildly dependant older (2016)[7]				
Edentulous (no teeth)	**	N/A	32.4%	27%
Of those with teeth - reporting pain in mouth	**	N/A	9.7%	9.5%
% evidence of infection/sepsis	**	N/A	10.7%	7.8%
Oral cancer[4] Standardised rate per 100,000				
Incidence - lip, oral cavity and pharynx (C00-C14)	16.24	N/A	15.26	14.55
Incidence - oral cavity (C00- C06)	9.48	N/A	8.7	8.36
Mortality - lip, oral cavity and pharynx (C00-C14)	5.06	N/A	4.7	4.54
Mortality - oral cavity (C00- C06)	2.27	N/A	2.18	2.19
**Did not participate in survey				

Red - worse than YH and England; **Amber** -worse than YH but better than England; **Green** – better than YH and England

Commissioned dental services

	Leeds	WY ICB	YH	England
Primary Care Services				
Numbers of GDS providers	93	265	611	
Wards in Leeds with an NHS dental practice	30 wards. 9 - IMD decile 1- (most deprived)			
Wards without an NHS dental practice in Leeds	Little London and Woodhouse (IMD 2) Ardsley & Robin Hood (IMD 4) Harewood (IMD 9)			
UDAs commissioned (2019-20)	1,213,408	3,827,464	8,665,024	
UDAs delivered (2019-20)	1.066,032	3,489,016	8,003,442	
Total value of commissioned UDAs	£36,636,512	£120,585,967.51	£285,954,684.20	
UDAs commissioned per capita	1.52	1.59	1.6	
Specialist primary care services				
Orthodontic providers	6 - (Leeds North 2; Leeds Central 2; Leeds South 2)	31	75	
IMOS providers	2	8	19	
CDS providers	1 (Leeds Community Healthcare Trust)	4	9	
Dental Access[8]				
Adult *(% pop^{n} in 24 months to 30th June '22)*	37.5%		41.8% (NHS NEY)	37.4%
Child *(% pop^{n} in 12 months to 30th June '22)*	50.6%		48.9% (NHS NEY)	46.9%
Oral Health Prevention				
Fluoride varnish - (0-17yrs)[9] - *FP17 forms (Nov 2021-Oct 2022*	56.0%	56%	59.5%	54.6%
Innovation in primary care				
Flexible commissioning practices	23	56	152	
Practices in Access scheme	7	29	55	
Practices providing additional urgent access sessions (to end March 2023)	22	47	106	
Practice locations prioritised under 'Golden Hello' scheme (IMD 1)	2	27	120	

Red - worse than YH and England; **Amber** -worse than YH but better than England; **Green** – better than YH and England

Figure 1: NHS GDS providers in Leeds superimposed on deprivation (IMD, 2019) (darker = more deprived).

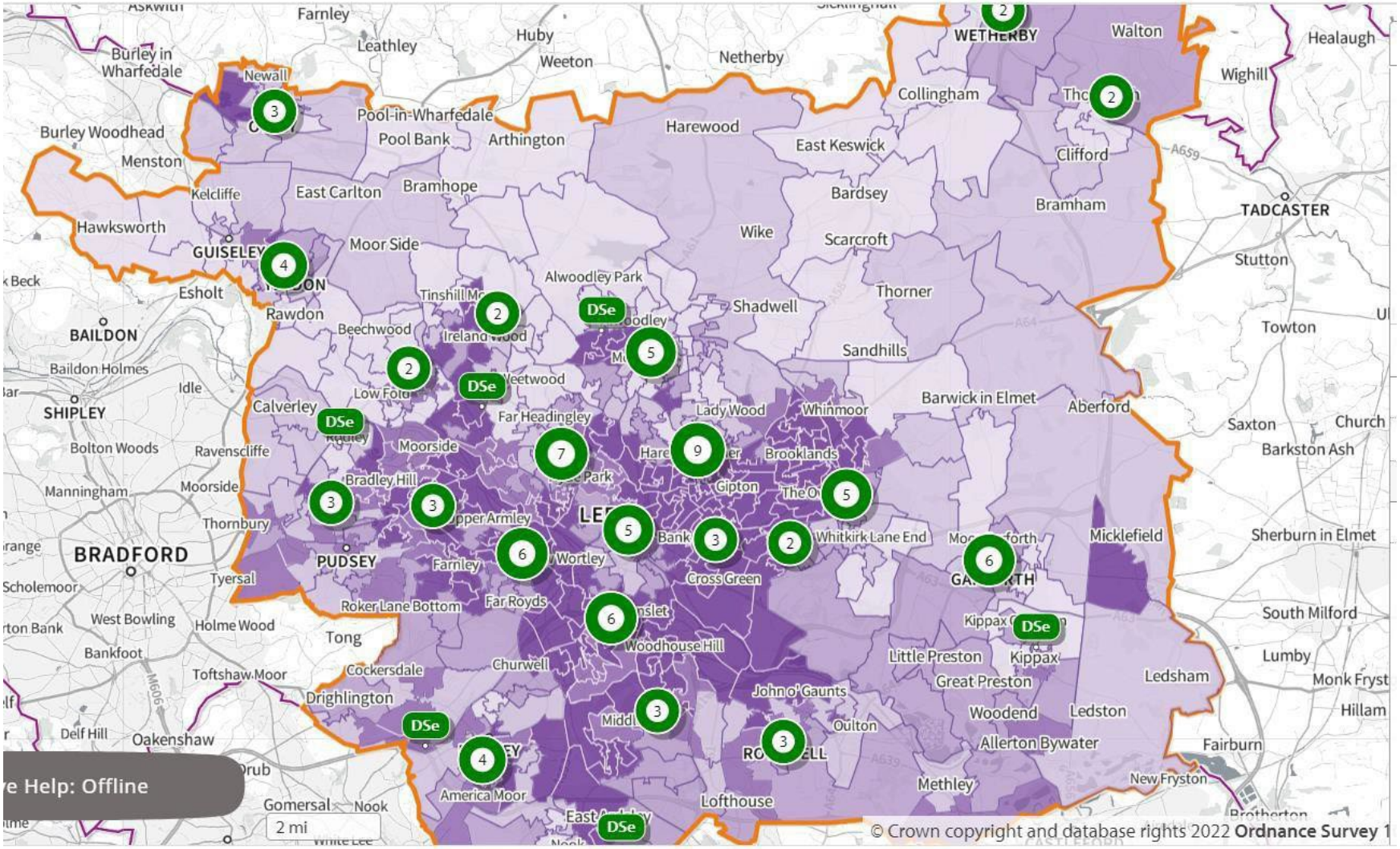
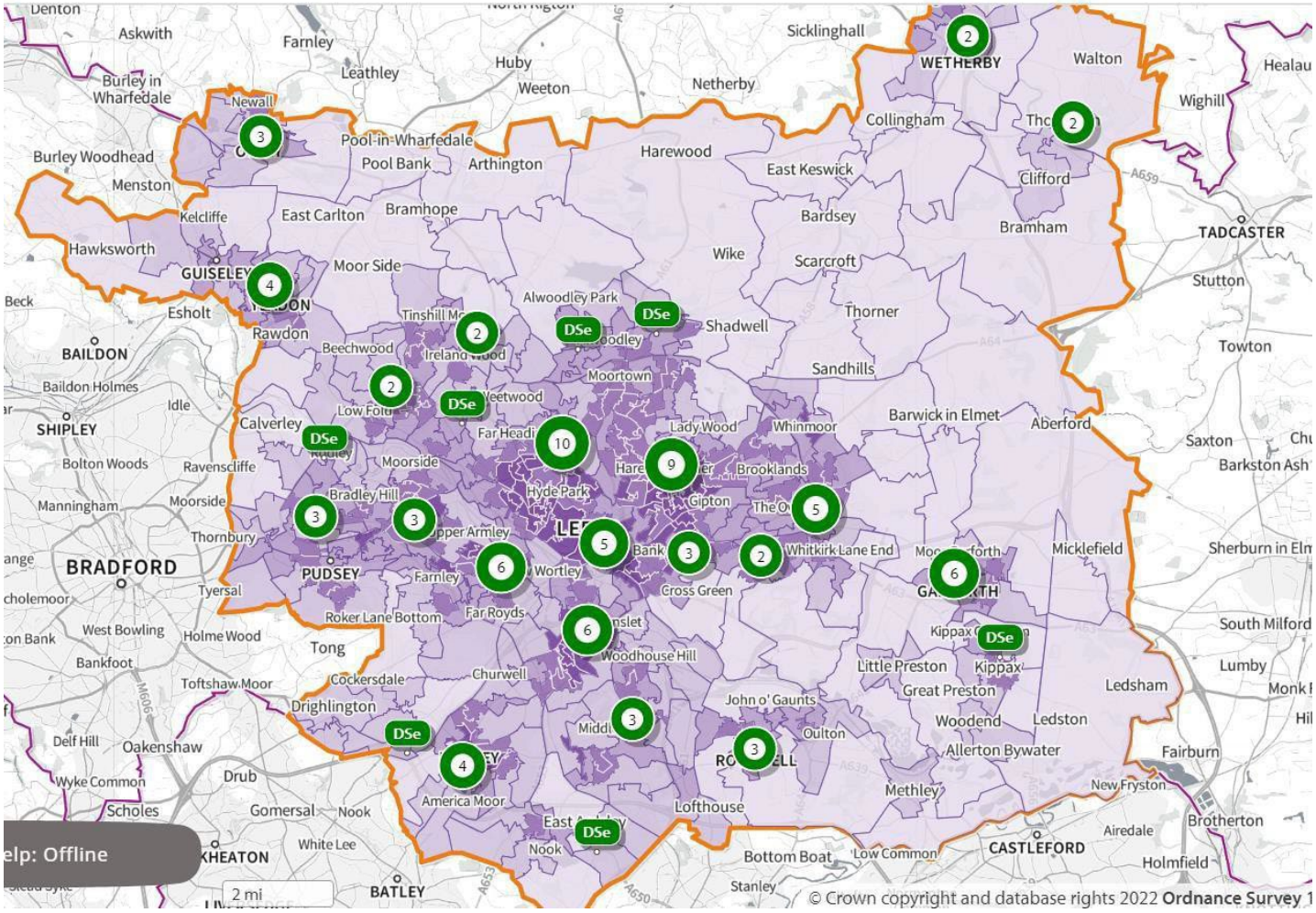


Figure 2: NHS GDS providers superimposed on population density (mid-2020) for Leeds (darker = greater population density) with mapped (source NHSBSA)



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Dental Locality Profile –

Wakefield March 2023

Overview

- Wakefield is a unitary authority in West Yorkshire (population 351,592) which in common with the remainder of the region has an **increasing and ageing population**. However, it is also the only local authority in YH with **projected increase in child population**[1].
- There is a relatively small but growing ethnic minority population[2].
- 15.7% of the population live in the 10% most deprived areas[2]. Deprivation is strongly correlated with experience of dental disease for both children and adults.
- The prevalence of chronic conditions (CVD, diabetes) is higher than the national rates. These conditions share common risk factors (tobacco, and sugar and alcohol consumption) with oral diseases[3].
- Although rates of smoking and alcohol consumption have reduced in Wakefield the long-term effects are reflected in higher rates of incidence of oral cancer[4].

Positives

- Children's oral health continues to improve in Wakefield but is still below the national average for 5-year-olds [5].
- Distribution of practices across Wakefield is good with practices focussed in areas of population density and includes more deprived areas (see maps).
- Access rates for both adults and children in Wakefield are higher than the national rates.
- UDAs commissioned per capita in Wakefield is higher than WY ICB and YH
- High delivery of commissioned UDAs (more than 95% in 2019/20).
- Primary care specialist orthodontic and IMOS practices.
- Good local engagement with YH developments (transitional / flexible commissioning, access programme).
- Local development of level 2 paediatric services in NHS dental practice (pilot imminent)
- Active local authority led Oral Health Action Group (OHAG)with an oral health plan in place and commissioned evidence informed prevention programmes focussed on children (including improving access to fluoride and reducing sugar consumption) and focussed work on access to dental assessment and care for looked after children.

Challenges

- **Poor oral health is largely preventable**. Oral disease developed in childhood has lifelong consequences. Access to timely prevention and care needs to adopt a **life course approach** and should include increasing access to fluorides, dietary control of sugars and reducing tobacco and alcohol use.
- There is no simple formula for **estimation of unmet need** in an area. Dental needs can be unmet due to a variety of reasons (waiting lists/volume commissioned, cost, physical access to premises, ability to travel, opening hours/ability to take time off work/caring

responsibilities). Most patients would like a relationship/registration with a named practice of the type that exists for general medical services and to access those services as they choose (either regularly or only occasionally or when they have an urgent need). GP practices have patient lists whilst dental practices are contracted to delivery activity. Dental practices are obliged only to deliver a course of treatment to an individual, not ongoing regular care however many practices do tend to see patients regularly.

- **Expectations of retaining some or all dentition for life** will be resource intensive. Maintenance of a heavily restored dentitions is complex potentially requiring specialist skills and often compounded by medical complexity, polypharmacy and the ability to self-care as an individual ages.
- **Access to data** – the local authority has the commissioning responsibility for the epidemiology fieldwork but are currently unable to secure a provider. There will be no further updates to the data currently reported in the oral health needs assessment unless this situation is addressed as a priority. It is essential that epidemiological surveys continue to be commissioned to enable identification of oral health inequalities.
- **Access to dental care** is the commonest reason for calls to Healthwatch Wakefield who have recently reported that in the past year 94 people have provided feedback on local dental services (14 positive; 68 negative/areas for improvement)[6].
- Local engagement in Wakefield has also highlighted access to dental provision for **care home residents** and the **migrant and asylum seeker population** as areas of concern.

Current workstreams

- Review of YH **Community Dental Services** which has led to focussed work on recovery of dental GA services, workforce development (including level 2) and development of dental sedation services.
- NHSE YH accreditation of **level 2 paediatric practitioners** from the 1st cohort of the 2yr training programme developed by HEE YH. 3rd training cohort currently being recruited. Level 2 paediatric pilot in a Wakefield dental practice working within a consultant led paediatric pathway is imminent.
- **Level 2 Special Care** Dentistry training programme has also been developed and the 1st cohort are being recruited.
- **Transformational commissioning** – review and further development / merging of flexible commissioning and access programmes focussed on need and addressing inequalities.
- **Waiting list validation** – seeking to understand how practices record and manage waiting lists.
- **Domiciliary care –** access to dental care for those patients who are for housebound and unable to access local dental practices.
- **Homeless –** sessional model in dental practices piloted in Leeds to be rolled out to other targeted areas of YH including Wakefield.

In the future we need to consider….

- **Access to prevention** interventions for all ages (life course), including expansion of delivery of prevention focussed practices (transformational/flexible commissioning)
- Patient facing **communications** – NHS dentistry how and when to access, recall intervals based on need (NICE guidance)
- Development of pathways that meet the **needs of an ageing population** - not just domiciliary services. Integration of pathways with the wider system (eg. post diagnosis), development of the dental team (level 2 SCD etc), estate/physical access.
- **Investment** – focussed on need and addressing inequalities. The OHNA assessment and commissioning data leads to the identification of the following areas:

Reallocation of resources to existing practices (within year / small numbers of UDAs)	
Wards with the highest level of deprivation (IMD 1) in the first instance.	Airedale and Ferry Fryston Hemsworth Knottingley Wakefield East Wakefield West South Elmsall and South Kirby
Commissioning in a new location/recommissioning in an existing location/retaining an existing practice	
IMD 3 - no GDS services commissioned	Pontefract South Wakefield South
IMD 4 - no GDS services commissioned	Altofts and Whitwood
IMD 1 – GDS services commissioned	South Elmsall and South Kirkby Wakefield West Airedale and Ferry Fryston Hemsworth Knottingley Wakefield East

Investment decisions should also consider:

- Population distribution – see maps.
- Accessibility / transport links
- Contract delivery – poorer delivery may have underlying factors that investment may mitigate, for example opportunities for career/practice development/specialisation
- Contemporary intelligence from key local stakeholders

Population and their oral health needs

	Wakefield	WY ICB	Yorkshire & the Humber	England
Population[1]	351,592			
Predicted change in population (2020-2040) -All ages	17%	6%	6%	
0-19 years of age	13%	-1%	-2%	
20-64 years of age	11%	1%	0%	
65+ years of age	40%	34%	33%	
85+ years of age	77%	63%	66%	
Epidemiology				
5-year-olds (2019)[5,7]				
% with experience of decay	25.4%	N/A	28.7%	23.4%
Mean number of teeth affected in those with decay (mean dmft (dmft>0))	3.5	N/A	3.8	3.4
% with sepsis	1.4%	N/A	1.4%	1%
Mildly dependant older (2016)[8]				
Edentulous (no teeth)	50%	N/A	32.4%	27%
Of those with teeth - reporting pain in mouth	6.1%	N/A	9.7%	9.5%
% evidence of infection/sepsis	0%	N/A	10.7%	7.8%
Oral cancer[4] Standardised rate per 100,000				
Incidence - lip, oral cavity and pharynx (C00-C14)	16.73	N/A	15.26	14.55
Incidence - oral cavity (C00- C06)	10.55	N/A	8.7	8.36
Mortality - lip, oral cavity and pharynx (C00-C14)	5.14	N/A	4.7	4.54
Mortality - oral cavity (C00- C06)	2.69	N/A	2.18	2.19

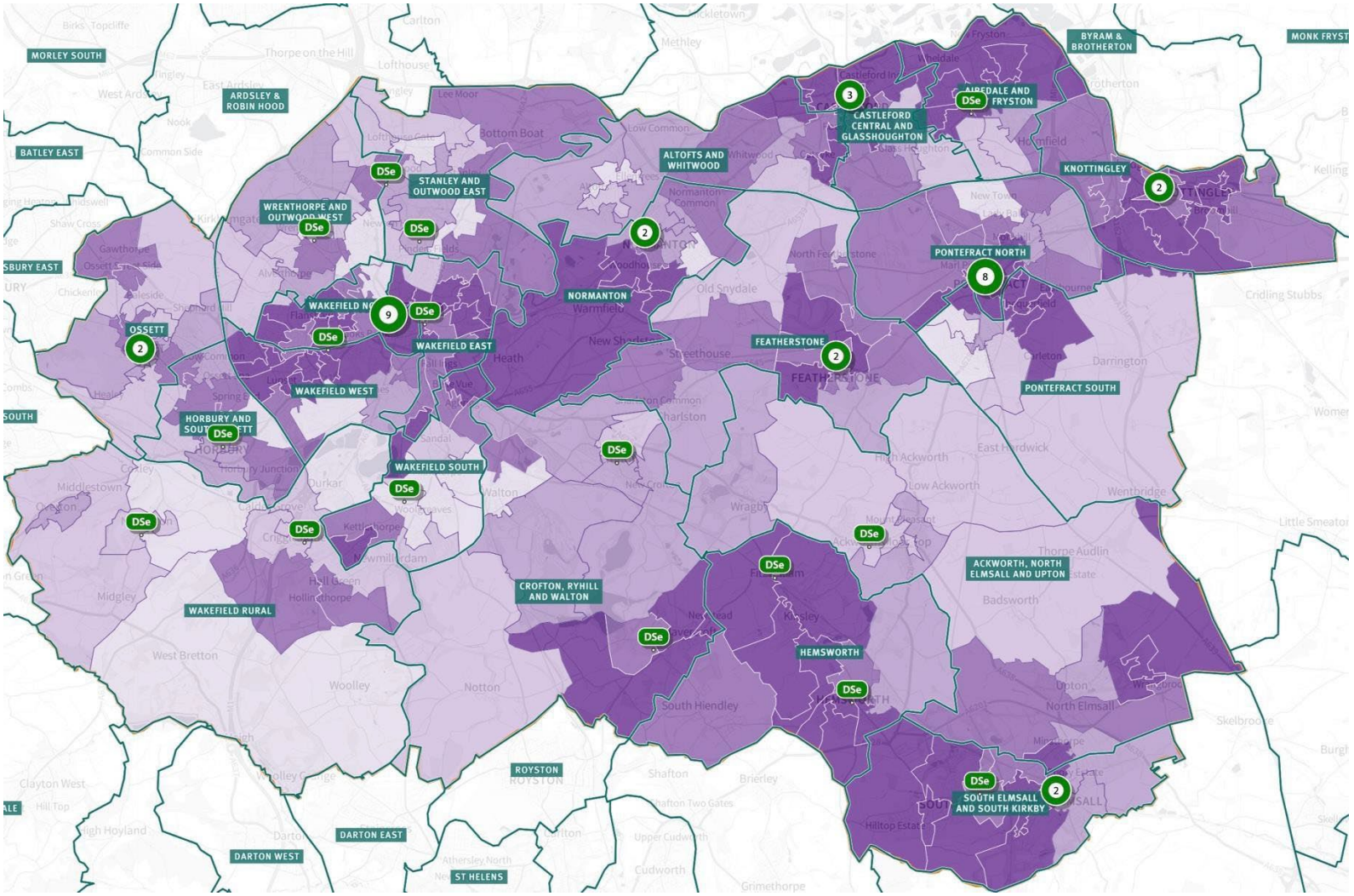
Red - worse than YH and England; **Amber** -worse than YH but better than England; **Green** – better than YH and England

Commissioned dental services

	Wakefield	WY ICB	YH	England
Primary Care Services				
Numbers of GDS providers	33	265	611	
Wards in Wakefield with an NHS dental practice	24 wards. 8 - IMD decile 1- (most deprived)			
Wards without an NHS dental practice in Wakefield	Pontefract South (IMD 3) Wakefield South (IMD 3) Altofts and Whitwood (IMD 4) Stanley and Outwood East (IMD 6)			
UDAs commissioned (2019-20)	633,238	3,827,464	8,665,024	
UDAs delivered (2019-20)	603,805	3,489,016	8,003,442	
Total value of commissioned UDAs	£20,444,6670	£120,585,967.51	£285,954,684.20	
UDAs commissioned per capita	1.8	1.59	1.6	
Specialist primary care services				
Orthodontic providers	4 - (2 Wakefield West & 2 Wakefield East)	31	75	
IMOS providers	2	8	19	
CDS providers	1 (Mid Yorks NHS Trust)	4	9	
Dental Access[9]				
Adult *(% popⁿ in 24 months to 30th June '22)*	41.5%		41.8% (NHS NEY)	37.4%
Child *(% popⁿ in 12 months to 30th June '22)*	49.7%		48.9% (NHS NEY)	46.9%
Oral Health Prevention				
Fluoride varnish - (0-17yrs)[10] - *FP17 forms (Nov 2021-Oct 2022*	59.4%	56%	59.5%	54.6%
Innovation in primary care				
Flexible commissioning practices	10	56	152	
Practices in Access scheme	1	29	55	
Practices providing additional urgent access sessions (to end March 2023)	5	47	106	
Practice locations prioritised under 'Golden Hello' scheme (IMD 1)	2	27	120	

Red - worse than YH and England; **Amber** -worse than YH but better than England; **Green** – better than YH and England

Figure 1: NHS GDS providers in Wakefield superimposed on deprivation (IMD, 2019) (darker = more deprived).



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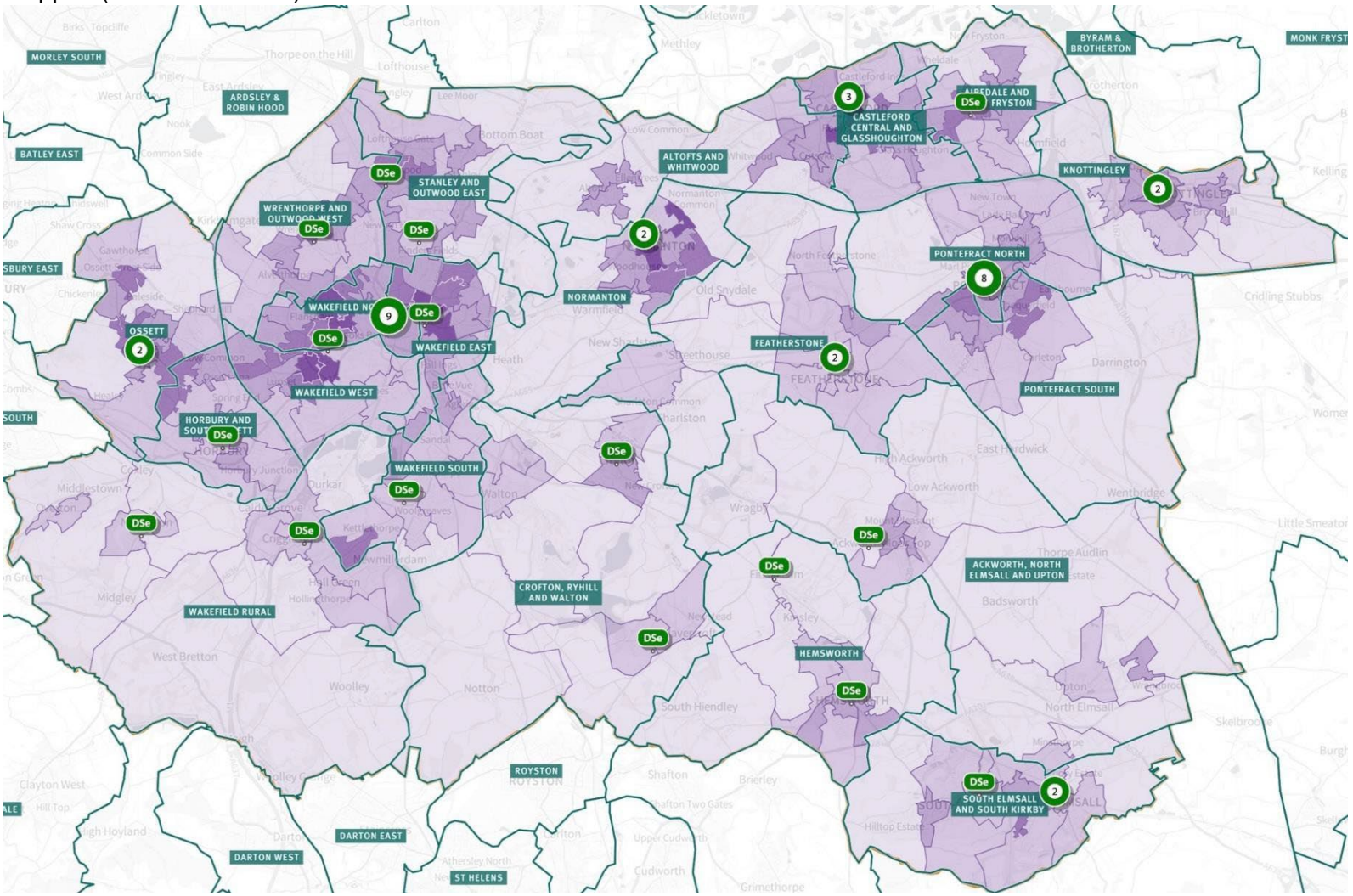

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BRUSH

optimising toothBrushing pRogrammes in nUrseries and ScHools

A quarter of five-year-old children in England have tooth decay. This figure can rise to 50% in deprived areas of the country. The burden of decay is significant. Decay causes pain and suffering, as well as affecting what children eat, their speech, quality of life, self-esteem, and social confidence. In addition, decay has a wider societal impact on school readiness and attendance. In England, treatment of decay is the most common reason why young children (over 33,000 per annum) are admitted to hospital, costing the NHS over £30 million every year.

Tooth decay is preventable. One key behaviour for preventing tooth decay is toothbrushing with a fluoride toothpaste. For many reasons, toothbrushing behaviours at home are variable. To supplement behaviours at home, nursery and school-based (Foundation and Year 1) toothbrushing programmes have been recommended. These supervised toothbrushing programmes are effective in reducing tooth decay, especially in children at greatest risk and are cost effective. However, uptake and maintenance of these programmes is fragmented with funding coming from a variety of sources and there is considerable variation in how they are implemented.

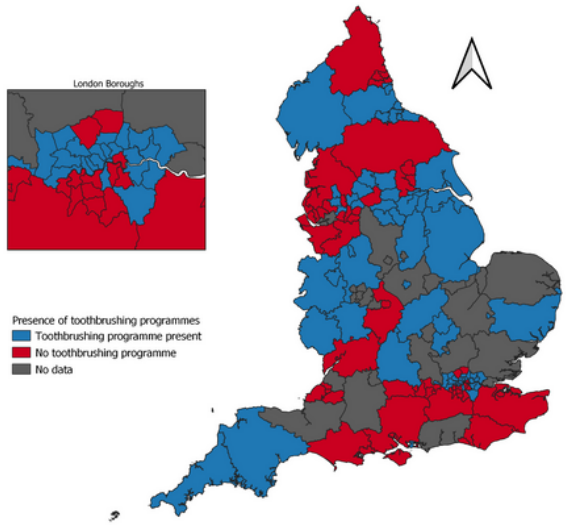
What we have done

This project is working with a range of stakeholders to learn how best to implement these programmes and how to increase their uptake and success in the longer term. We are using a variety of methods underpinned by implementation and improvement science to undertake this work, including:

- A **national stocktake** was undertaken in Spring 2021 of supervised toothbrushing programmes in nurseries and schools. Information was received from 141 local authorities across England. We will undertake a follow-up stocktake in Autumn 2023.

- **Geographical mapping** of toothbrushing programmes across England with variables such as deprivation level, levels of tooth decay in children, number of hospital admissions for tooth extraction under general anaesthetic, dental access, rurality and early-years education data. We will examine current geographic spread of supervised toothbrushing programmes and the utility of variables for targeting these programmes to improve children's oral health.

Hina the Storyteller leading the interactive storytelling session



Results of the stocktake survey - presence of Supervised Toothbrushing Programmes

- **Qualitative interviews** with all the key stakeholders involved in running a toothbrushing programme – Commissioners, Oral Health Trainers/Co-ordinators, Organizations (i.e., nurseries, schools, childminders), Practitioners (i.e., nursery/school staff), parents and children. We have interviewed 153 participants across England to explore in-depth the barriers and facilitators to implementing toothbrushing programmes.

- **Co-design the implementation toolkit** for supervised toothbrushing programmes with stakeholders at all levels of implementation. We are holding sessions with stakeholders to discuss our findings and reflect on what resources are already available, their quality and what the gaps are that need addressing to aid implementation. The outcome of these co-design sessions will be a toolkit that includes resources both to improve implementation and sustain the intervention over time.

- **Pilot testing the toolkit** in a small number of sites who are seeking to develop or expand their toothbrushing programme.

BRUSH is funded by the NIHR ARC South West Peninsula and Yorkshire and Humber through the Children's Health and Maternity National Priority Programme (https://arc-swp.nihr.ac.uk/research/projects/childrens-health-and-maternity-programme/)

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Future plans

The toolkit will be freely available. To help local organisations and settings implement toothbrushing programmes, further funding will be sought to undertake follow-up stocktake surveys to monitor implementation and wider scale testing of the implementation toolkit to fully assess its impact.

Hina the Storyteller leading the interactive storytelling session

Background to the BRUSH project and wider context

We are working with the following local and national bodies to discuss our findings and inform local and national policy.

National: Office for Health Improvement and Disparities, NHS England Transformation Programme Team for Oral Health, Department for Education, Designed to Smile (the team behind the national oral health promotion programme in Wales), University of Plymouth, Regional and Beyond PSHE and Healthy Schools network, The Hygiene Bank (a charity) and the University of Trondheim in Norway.

Local: The Centre for Applied Educational Research, Department for Education Stronger Practice Early Years Hub – Bradford, Yorkshire and Humber Dental Public Health consultants, Lancashire and Cumbria Oral Health Improvement Group, University of Sheffield, Bradford Improvement Academy, Patient and public involvement and engagement groups (school staff, parents, children).

Poor oral health in childhood has lifelong impacts. CORE20PLUS5 – Children and Young People, is a national NHS England initiative that aims to reduce health inequalities at a national and system level by targeting the most deprived 20% of the population. It identifies oral health as one of its five clinical areas requiring accelerated improvement, with supervised toothbrushing programmes advocated as an effective public health intervention.

Example of a toothbrush rack made by AMS International

Further information

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HABIT

Health visitors delivering **A**dvice in **B**ritain on **I**nfant **T**oothbrushing

In England, a quarter of children have tooth decay by five years old. Decay causes pain, discomfort when eating, problems with speech development and negatively impacts educational outcomes. Decay is the most common reason for young children to have a general anaesthetic, with significant morbidity to the child and costs to their family and the NHS. There are clear inequalities, with deprivation and ethnicity strongly associated with decay. In Bradford, 36% of five-year-olds have decay.

Tooth decay is preventable. National guidance identifies key home-based oral health behaviours as the foundations for preventing decay. These behaviours include brushing with a fluoridated toothpaste twice a day and limiting the intake of sugary food and drinks. Whilst many parents are aware of these behaviours, supporting families to implement them at home can be challenging. In Bradford, less than 5% of children under the age of one attend the dentist. Early-years professionals can support children's oral health in addition to dental teams. Public Health England's Return On Investment tool shows clear benefits for the role of Health Visitors in supporting children's oral health. In England, the Healthy Child Programme ensures all infants receive five visits from their Health Visitor between 0-24 months. Oral health is a key topic for these visits. There is, however, no mandatory oral health training for Health Visitors, and there are inconsistencies in what and how oral health advice is provided.

Funded by the MRC, the HABIT intervention has been co-designed with parents and Health Visitors based in Bradford. It aims to optimise oral health conversations and enable parents to establish and implement key oral health habits in infancy; thereby improving children's oral health. We have shown that the HABIT intervention is acceptable to parents, feasible to be delivered by Health Visitors and leads to the adoption of key oral health habits by parents of infants. HABIT is now being adopted as core practice for Health Visitors in Bradford.

What is HABIT

HABIT supports Health Visitors, and their wider team, to have effective oral health conversations with parents of infants. It is underpinned by robust behaviour change theory (including systematic reviews, qualitative interviews, intervention mapping and community engagement). As part of HABIT, Health Visitors receive a half day training session to update their oral health knowledge, with a strong focus on how to have effective oral health conversations with families. To support these conversations, several parent-facing resources have been developed, including: toothbrushing models, leaflet, website and six oral health videos. Health Visitors follow a standardised protocol. Some flexibility is retained to allow conversations to be adapted to individual parent needs while ensuring key activities take place such as a toothbrushing demonstration and creating an action plan.

Better Start Bradford

COMMUNITY FUND

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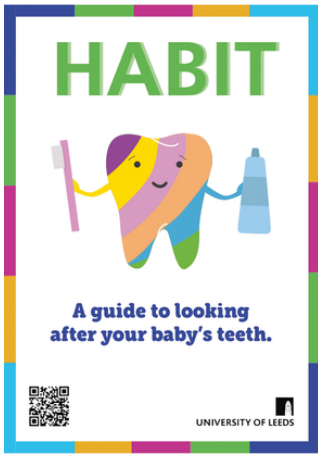
HABIT

What we have done

Since the feasibility study, further funding from Better Start Bradford has allowed us to refine the HABIT intervention. This includes changes to parent-facing resources to improve accessibility and understanding for parents with limited English. For Health Visitors, iterations to training have helped the consistency of oral health conversations. This includes the opportunity to practice these conversations with actors using forum theatre, video examples of good practice and preceptorship meetings with senior Health Visitors. Templates developed for SystemOne have allowed unique insight in to the clinical records of over 450 HABIT oral health conversations.



Collaborators

HABIT supports Health Visitors, and their wider team, to have effective oral health conversations with parents of infants. It is underpinned by robust behaviour change theory (including systematic reviews, qualitative interviews, intervention mapping and community engagement). As part of HABIT, Health Visitors receive a half day training session to update their oral health knowledge, with a strong focus on how to have effective oral health conversations with families. To support these conversations, several parent-facing resources have been developed, including: toothbrushing models, leaflet, website and six oral health videos. Health Visitors follow a standardised protocol. Some flexibility is retained to allow conversations to be adapted to individual parent needs while ensuring key activities take place such as a toothbrushing demonstration and creating an action plan.

Key research papers

Owen, J., Gray-Burrows, K.A., Eskytė, I. et al. Co-design of an oral health intervention (HABIT) delivered by health visitors for parents of children aged 9–12 months. BMC Public Health 22, 1818 (2022). doi.org/10.1186/s12889-022-14174-w

Bhatti, A., Wray, F., Eskytė, I. et al. HABIT (Health visitors delivering Advice in Britain on Infant Toothbrushing): a qualitative exploration of the acceptability of a complex oral health intervention. BMC Prim. Care 23, 55 (2022). doi.org/10.1186/s12875-022-01659-1

Giles E, Wray F, Eskyte I, et al. HABIT: Health visitors delivering Advice in Britain on Infant Toothbrushing – an early-phase feasibility study of a complex oral health intervention. BMJ Open 12 (2022). doi:10.1136/ bmjopen-2021-059665

Further information

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Better Start BRADFORD

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Empowering families with young autistic children to establish good oral health habits

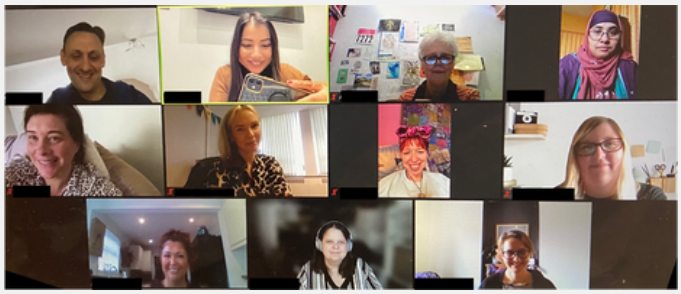
Tooth decay is a significant yet preventable health problem affecting a quarter of five-year-olds in England. This directly impacts their quality of life which, left untreated, causes toothache, sleepless nights and altered eating habits. Autistic children have similar levels of tooth decay to the wider childhood population (e.g. 1 in 4 children affected) but are less likely to visit the dentist and are twice as likely to need their dental treatment provided under a general anaesthetic. In England, treatment of decay is the most common reason why young children (over 33,000 per annum) are admitted to hospital, costing the NHS over £30 million a year.

Establishing good habits (such as toothbrushing with a fluoride toothpaste, limiting sugary foods and drinks, and regularly going to the dentist) from early childhood provides a lifetime of protection, leading to good oral health. Autistic children have additional challenges, such as communication difficulties, altered sensory sensitivities and rigid behaviour patterns, making good oral health habits difficult for families to establish. Our research found that parents with autistic children often feel alone, confused and uncertain where to ask for help. Usually, the advice they receive around oral health is generic and does not address specific autism challenges. As autistic children are less likely to attend the dentist or receive preventive advice, parents often ask oral health questions to other early-years professionals. We found early-years professionals had limited oral health training and were uncertain of what advice to give.

We created a prototype of a support package for families with young autistic children. We now want to take the prototype and build it into a fully functioning toothPASTE intervention (including a website, resources and professional training). Once funded, we will take eight months to build and user-test the intervention. The toothPASTE intervention will be available to parents, early-years professionals and dental teams across West Yorkshire to support families with young autistic children to have good oral health.

What we have done

We co-designed our research with a parent panel from its inception. The panel comprises of six members, all with experience of autism, such as having an autistic child, being autistic themselves, or as a parental advocate for an autism charity. In stage one, we interviewed autistic children (n=10), families of young autistic children (n=14), and early-years professionals (n=29) who care for them. Together, we explored the barriers and facilitators to good oral health habits in order to help inform the design of the support package.



Our First PPIE meeting with members of our research team and PPIE panel

toothPASTE prototype for website and resources

In stage 2, we co-designed the prototype support package by running a full-day workshop with approximately 40 key stakeholders from the early-years' workforce. This included our parent panel, stakeholders involved in developing national policy and stakeholders involved in delivering early-years services at a local level in West Yorkshire. We undertook three further co-designed workshops with our parent panel and approximately ten early-years professionals likely to deliver the support package. Each workshop had a different focus around toothbrushing, healthy eating and drinking, and going to the dentist. This research has identified what support families need (including a website and resources) and a training package aimed at early-years professionals to feel confident that the oral health advice that they are giving is correct and sensitive to the family's needs. Establishing good habits in early life can provides the foundations for long term oral health and reduces the impact of tooth decay for autistic children, their families, the NHS and wider society.

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"Taking Mats" symbols adapted with our PPIE panel to facilitate our interviews with autistic children

Future plans

Short term, we are looking for funding to co-develop the support package prototype into a full set of resources in a format which is acceptable to parents, autistic children and early-years professionals. Following this, we will run a feasibility trial to establish the impact of our support package.

toothPASTE co-design workshop summary illustration

Background to the toothPASTE project and wider context

We have worked with the following local and national bodies to publicise our findings and discuss future plans, including the further development and feasibility testing of the package:

- National: National Autistic Society, Autistica, Office for Health Improvement and Disparities, NHS England Transformation Programme Team for Autism and Oral Health, Department for Education, University of Plymouth, British Society of Paediatric Dentistry, Office of the Chief Dental Officer.
- Local: AWARE (Airedale & Wharfedale Autism Resource), The Whole Autism Family, West Yorkshire Integrated Care Board, Bradford Opportunity Area and the Centre for Applied Educational Research, West Yorkshire Autism Deep Dive.

Poor oral health in childhood has lifelong impacts. Oral health behaviours such as brushing twice a day with a fluoride toothpaste, limiting sugary foods and drinks, and going to the dentist are critical, although particularly difficult for autistic children to establish.

This research aligns with the NHS Long Term Plan and its commitment to ensuring all people with autism live happier, healthier and longer lives. It has a clear emphasis on primary prevention, reducing health inequalities and integrating oral health into early years services.

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