



Cambridgeshire and Peterborough  
Public Health Network

# Oral Health Strategy

January 2009

---

**Amanda Crosse,  
Consultant in Dental Public Health  
Cambridgeshire and Peterborough Public Health Network**



# Oral Health Strategy

## Content

	<b>Page</b>
<b>1. SUMMARY</b>	
1.1 Introduction .....	5
1.2 Oral Disease .....	5
1.3 Underlying Causes of Oral Health .....	5
1.4 Common Risk Factor Approach .....	6
<b>2. KEY ROLES AND RESPONSIBILITIES FOR NHS CAMBRIDGESHIRE AND NHS PETERBOROUGH (PRIMARY CARE TRUSTS)</b>	
2.1 Dental Contracts .....	8
2.2 Access to Dental Services .....	8
2.3 NHS East of England (Strategic Health Authority) .....	9
<b>3. PURPOSE .....</b>	<b>10</b>
<b>4. REFERENCES .....</b>	<b>24</b>
<b>5. GLOSSARY .....</b>	<b>25</b>

## **Oral Health Strategy Working Group:**

Mr David Adlam	Consultant in Oral and Maxillofacial Surgery Cambridge University Hospitals NHS Foundation Trust
Ms Tracey Cooper	Service Manager, Hunts and Wisbech Dental Access Centres, NHS Peterborough
Mr Richard Cousley	Consultant Orthodontist, Peterborough and Stamford Hospitals NHS Foundation Trust
Ms Amanda Crosse	Consultant in Dental Public Health, Cambridgeshire and Peterborough Public Health Network
Dr Jennifer Donaghy	Previously of Cambridgeshire and Peterborough Public Health Network
Ms Jane Freeman	PEC Member, NHS Peterborough
Mr John Griffiths	Clinical Lead, Hunts Dental Access Centre
Mr Tony Holland	Local Dental Committee Representative
Mr Clive Moss	Consultant in Oral and Maxillofacial Surgery, Peterborough and Stamford Hospitals NHS Foundation Trust
Mrs Rowena Rimes	Consultant Orthodontist, Cambridge University Hospitals NHS Foundation Trust
Mr Nicholas Roberts	Patient representative
Mr Tim Rodgers	Local Dental Committee Representative
Dr Maria Ross-Russell	NHS Cambridgeshire
Ms Diane Siddle	Senior Contract Manager, NHS Peterborough
Mr Christopher Sprinz	Dental Surgeon, Bushfield Dental Practice
Mr Mark Thompson	Consultant Maxillofacial Surgeon, Cambridge University Hospitals NHS Foundation Trust
Mr Kerry Tolhurst	Local Dental Committee Representative
Mr Jeremy Wallman	Primary Care Development Manager, NHS Cambridgeshire

# **1. SUMMARY**

## **1.1 Introduction**

People living in Cambridgeshire and Peterborough should enjoy a standard of oral health which is among the best in the country. Within this context the aims of government and local policy are to reduce inequalities by enabling people to take control of their own oral health. The challenge is to create the opportunity and conditions to enable individuals and communities to enjoy good oral health as a fundamental part of overall good health.

## **1.2 Oral Disease**

Oral diseases are important public issues as they are among the most commonly found chronic diseases. Although we have seen considerable reductions in dental diseases since the 1970s there are still substantial reductions to be made. Dental decay, for example, is commonly found despite being entirely preventable.

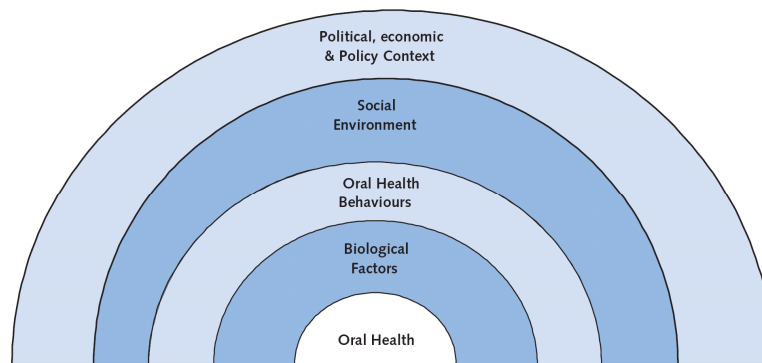
While dental decay has reduced overall, population averages mask oral health inequalities. Oral disease varies according to gender, age, ethnicity, geographic location and socio-economic group. Trends suggest that dental disease is increasingly concentrated in areas of social deprivation.

Oral diseases, such as dental decay and periodontal (gum) disease are largely preventable. Interventions need to focus on achieving long term improvements in oral health and any action should create conditions that support and encourage good oral health. For example changes which promote healthier food and drink choices in schools help to create a school environment conducive to good oral health.

## **1.3 Underlying Causes of Oral Health**

For sustainable reductions in oral health inequalities it is important to tackle the underlying causes of oral diseases. It is now well recognised that oral health is determined by a wide range of factors from individual lifestyle factors (eg the amount of sugar in the diet) to environmental factors such as national policy around smoke free environments, and seat belt legislation. A successful public health approach must focus on these wider determinates of health as well as on service provision. (Figure 1).

**Figure 1: The Underlying Causes of Oral Health**



Source: Modified from Watt, 2005 in Department of Health Choosing Better Oral Health. An Oral Health Plan for England 2005. Available at URL: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4123251](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123251)

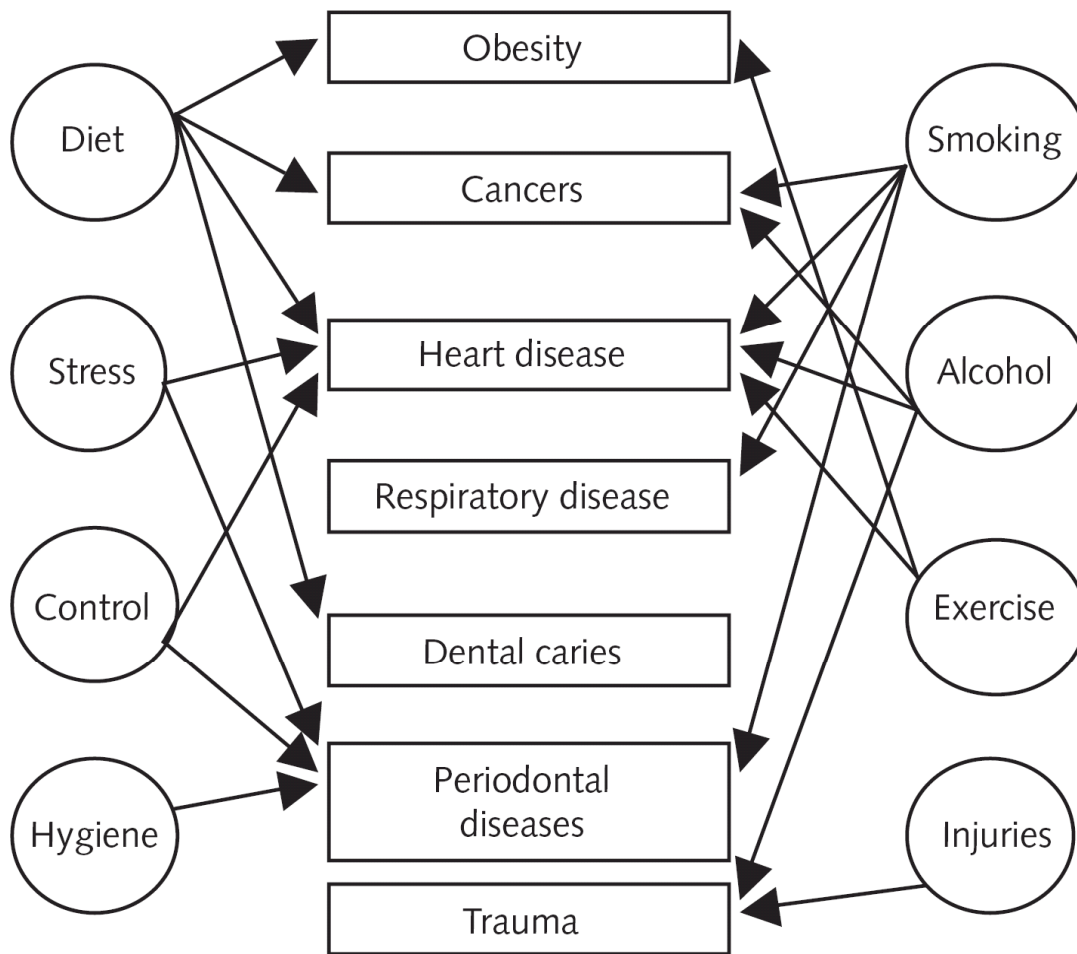
#### **1.4 Common Risk Factor Approach**

The provision of high quality dental services is only one aspect of the public health action needed to reduce oral health inequalities. Dental services are by necessity treatment focussed and cannot eliminate oral health inequalities alone no matter how accessible or effective they may be.

Evidence suggests that tackling the causes of oral diseases and promoting oral health will reduce oral health inequalities. The most effective and efficient method of promoting oral health is to integrate oral health promotion with generic health promotion. The Common Risk Factor Approach emphasises the need to tackle the common risk factors and conditions that are shared by chronic non-communicable diseases.

These common risk factors include tobacco use, poor diet, stress, alcohol consumption, poor hygiene, injuries and a sedentary lifestyle. Targeting these risk factors at a population and individual level would help reduce the incidence of obesity, heart disease, stroke, cancers, diabetes and mental illness in addition to oral diseases. If the Common Risk Factor Approach is broadly adopted then strategic approaches to improving oral health will therefore be linked to other, more general, health promotion initiatives. (Figure 2). For example high sugar diets cause dental decay and smoking is a contributory and causative factor in periodontal disease and oral cancer.

**Figure 2: The Common Risk Factor Approach**



Source: Sheiham and Watt, 2000 in Department of Health Choosing Better Oral Health. An Oral Health Plan for England. 2005 Available at URL: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4123251](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123251)

## **2. KEY ROLES AND RESPONSIBILITIES FOR NHS CAMBRIDGESHIRE AND NHS PETERBOROUGH (PRIMARY CARE TRUSTS)**

Primary Care Trusts are required by the Department of Health to meet the oral health needs of their populations. Part of this planning involves an assessment of the local health needs of the population followed by the development of an oral health strategy. The local oral health strategy must incorporate the national priorities detailed in 'Choosing Better Oral Health – an Oral Health Plan for England', 'The NHS Operating Framework 2008/09', 'Delivering Better Oral Health' as well as other key documents.

### **2.1 Dental Contracts**

NHS dentistry was fundamentally reformed with the introduction of the new dental contract in April 2006. PCTs are responsible for the effective implementation of the new contract arrangements for dentistry, 'Health and Social Care Act (Community Health and Standards) 2003'.

To achieve this and meet the oral health needs of their population PCTs should consider:

- Ensuring that improving oral health is an integral part of their local delivery plans.
- Liaising with other organisations to ensure that improving oral health is included in joint planning objectives.
- Ensuring that dental services they commission have an evidence based focus.
- Ensuring that they are able to obtain appropriate health needs information and advice in developing local programmes for implementation.

### **2.2 Access to Dental Services**

Increasing access to NHS dentistry has become a national as well as a local priority and PCTs will continue to have a legal duty to provide or commission dental services to meet all reasonable requirements for the foreseeable future. 'NHS Operating Framework 2008/09'.

The Department of Health guidance 'Commissioning NHS primary dental care services: meeting the NHS Operating Framework Objectives January 2008' emphasises the need to expand dental services and increase access year on year through robust local commissioning.

PCTs are required to deliver the following:

- Year on year improvements in the number of patients accessing local dental services.
- Commission high quality services to achieve improved oral health.
- Ensure that commissioned services prioritise prevention as well as treatment.
- Tailor services to need with special attention paid to hard to reach groups.
- Provide better patient information about what services are available and how to access them.

### **2.3 NHS East of England (Strategic Health Authority)**

Access to dental services has become a priority for NHS East of England (Strategic Health Authority (SHA)). 'Improving Lives, Saving Lives' details 11 outcome based pledges. Pledge 4 focuses on dental services "We will ensure NHS primary dental services are available locally for all who need it".

To meet the pledge the PCTs will need to:

- Agree clear local standards for accessing NHS dentistry.
- Develop a methodology to identify areas that fall below agreed standards.
- Begin to expand provision of treatment services to ensure all areas meet agreed standards.
- Be in a position to give individual patients accurate information on the nearest NHS dentist that will offer them an appointment.

Both the Department of Health and Strategic Health Authority have set population targets for the number of new patients attending a dental practice to meet these so called Access Standards.

### 3. PURPOSE

The Oral Health Strategy builds on the oral health needs assessment and its purpose is to enable the PCTs to improve oral health and reduce oral health inequalities by informing PCT local commissioning and by facilitating and monitoring implementation and development of the process.

The strategy focuses on seven key areas:

- Reduce inequalities in health and wellbeing and improve oral health
- Improve access to services
- Improve the experience of service users and empower local communities
- Develop excellent integrated and appropriate services
- Invest resources effectively
- Information requirements
- Empowering and working with dental professionals.

The intention is that this is a living document with regular monitoring and priority setting each year embedded in the process. Key milestones will be developed and progress will be measured annually against targets.

#### Key to leads:

VC	Vladek Cirin
TC	Tracey Cooper
AC	Amanda Crosse
BD	Bob Dawson
AL	Andy Liggins
HL	Helen Lucas
LR	Liz Robin
MRR	Maria Ross-Russell
CCS	Cambridgeshire Community Services
SS	Sarah Shuttleworth
DS	Diane Siddle
VT	Val Thomas
JW	Jeremy Wallman

	Aim	Areas for action	Action Points	Priorities for action 2009-10	Lead
1.	Reduce inequalities in health and wellbeing and improve oral health.	Environment	<p><b>Dento-facial injuries</b></p> <ol style="list-style-type: none"> <li>1. Promote improvements in the quality of the environment, eg safer play areas, leisure facilities, schools and colleges.</li> <li>2. Ensure schools, colleges and other settings are aware of and adopt guidelines on first aid for dental injuries.</li> <li>3. Reduce trauma caused by violence and binge drinking by promoting links with alcohol misuse strategy.</li> </ol> <p><b>Diet/nutrition</b></p> <ol style="list-style-type: none"> <li>1. Promote the development and adoption of nutrition and healthy eating guidelines which include action on sugars in organisations where food and/or drinks are prepared and/or sold.</li> <li>2. Encourage caterers to reduce sugars content of prepared food, eg schools, prisons, hospitals.</li> <li>3. Encourage vending machine providers to include sugar free choices.</li> <li>4. Promote that healthy options are available where food is provided or sold.</li> <li>5. Ensure that it is possible to access 5 portion of fruit and vegetables daily in institutional settings, eg residential homes, prisons.</li> <li>6. Support the proportion of sugar free medicines prescribed and sold.</li> </ol> <p><b>Community fluoridation</b></p> <ol style="list-style-type: none"> <li>1. In line with government legislation, in areas with high caries levels, PCTs should explore the need and feasibility of water fluoridation.</li> </ol>	2009	AC LR/AL

1.	<b>Reduce inequalities in health and wellbeing and improve oral health.</b>	<b>Environment continued</b>	<b>Partnership working</b> <ol style="list-style-type: none"> <li>1. Ensure that oral health is integrated with general health across organisational boundaries.</li> <li>2. Ensure oral health in to healthy schools and other programmes, eg Sure Start.</li> <li>3. Incorporate oral hygiene teaching within general body cleanliness in Personal and Social Education teaching.</li> <li>4. Ensure that the oral health recommendations from prison health needs assessments, including Whitemoor, Littlehey and Peterborough, are actioned.</li> <li>5. Ensure individuals in residential and care settings have access to tooth brushing facilities and advice on oral hygiene.</li> <li>6. Support the broader obesity agenda.</li> </ol>		
		<b>Lifestyle</b>	<b>Dento-facial injuries</b> <ol style="list-style-type: none"> <li>1. Promote mouth guard wear for sports where risk of tooth damage is high.</li> <li>2. Consider locally funded scheme for provision of mouth guards.</li> </ol> <b>Diet/nutrition</b> <ol style="list-style-type: none"> <li>1. Discourage addition of sugars to weaning foods, drinks and vitamin supplements.</li> </ol> <b>Fluoridation</b> <ol style="list-style-type: none"> <li>1. Maximise the delivery of fluoride.</li> <li>2. Targeted fluoride varnish schemes in schools/community settings.</li> <li>3. Pilot fissure sealing initiative via salaried dental services.</li> <li>4. Increase the use of fluoride toothpaste, especially in young children in disadvantaged communities.</li> <li>5. Encourage parents and carers to start tooth brushing with fluoride toothpaste within the first year of a child's life.</li> </ol>	2010	AC / JW / DS

1.	<b>Reduce inequalities in health and wellbeing and improve oral health.</b>	<b>Lifestyle continued</b>	<b>Partnership working</b> <ol style="list-style-type: none"> <li>1. Support the broader tobacco control agenda, eg commission dentists to get involved in smoking cessation training to 1 and 2, as appropriate and increase referrals to smoking cessation services.</li> <li>2. Ensure that the common risk factor approach is adopted when developing oral health promotion interventions.</li> <li>3. Consider involving dental teams in providing advice on misuse of alcohol.</li> <li>4. Encourage improved oral hygiene/ reduced sugar intake in drug misusers.</li> <li>5. Challenge SHA imperatives which make no rational contribution to this strategy.</li> <li>6. Encourage close working with the Peterborough School Nursing Team to promote oral health improvement through the common risk factor approach.</li> </ol>	2009	VT
		<b>Services</b>	<ol style="list-style-type: none"> <li>1. Ensure that oral health will be adequately and appropriately addressed within all PCT strategy documents.</li> <li>2. Geographical targeting of service commissioning in socially deprived locations, eg Bretton, Fenland.</li> <li>3. Ensure that the oral health recommendations of Hepatitis C strategy are actioned.</li> <li>4. Ensure that the oral health recommendations of Travellers literature review are actioned.</li> <li>5. Ensure oral health input into local infant feeding strategies and guidelines.</li> </ol>		

1.	<b>Reduce inequalities in health and wellbeing and improve oral health.</b>	<b>Services continued</b>	<p>6. Improve access to services and oral health outcomes for vulnerable and hard to reach groups:</p> <ul style="list-style-type: none"> <li>o Looked after children (95% should have oral examination)</li> <li>o Children and adults with disabilities</li> <li>o Older people in residential homes</li> <li>o Children in areas of deprivation</li> <li>o Asylum seekers, eg Oakington Reception Centre residents</li> <li>o People with mental health problems</li> <li>o Prison population</li> <li>o Travellers and migrant workers.</li> </ul> <p>7. Commission oral health promotion interventions that are evidence-based and evaluated.</p> <p>8. Commission oral health promotion and school health promotion with an evidence-based content, through common risk factor approaches about diet and oral health behaviour.</p> <p>9. Develop evidence-based strategies to deliver fluoride at a community level, eg fluoride varnish, fluoride toothpaste distribution. This may be targeted to high risk populations where appropriate.</p> <p>10. Support policies on reducing binge drinking amongst young people.</p> <p>11. Disseminate guidelines on the use of protective head wear and gum shields during contact sports.</p> <p>12. Encourage availability of affordable mouth guards to reduce dental injury.</p> <p>13. Ensure oral health needs not neglected by patients being assessed for other care.</p> <p>14. Improve consistency of all dietary messages, particularly reducing the frequency of intake of sugary drinks and foods.</p> <p>15. Assess the feasibility of distributing fluoride toothpastes and brushes to young children in disadvantaged communities.</p>	2009	CCS / BD
----	---	---------------------------	--	------	----------

1.	<b>Reduce inequalities in health and wellbeing and improve oral health.</b>	<b>Services continued</b>	<ul style="list-style-type: none"> <li>16. Routinely assess the value of school screening and consider ways of maximising uptake of services as a result.</li> <li>17. Ensure that recommendations on use of fluoride toothpaste in Delivering Better Oral Health are given by the dental team and other health professionals and care staff.</li> <li>18. Improve the effectiveness of oral hygiene instruction provided by oral and other health professionals.</li> <li>19. Dental teams should routinely enquire about patient's tobacco use and to give smoking cessation advice, as part of the smoking cessation agenda.</li> <li>20. Skilled follow-up clinical treatment should be available to maintain injured teeth. The services of paediatric and restorative dental specialists should be available locally for treatment cases.</li> <li>21. In the case of dento-facial injuries ensure there is appropriate access in primary and secondary care. Establish a recognised care pathway for patients.</li> <li>22. Strengthen role of pharmacy team in oral health promotion and referral pathways</li> <li>23. Build strong links with healthy schools.</li> <li>24. Investigate outreach service provision to hard to reach groups.</li> <li>25. Consider pilot Oral Health Promotion programme in salaried services.</li> </ul>	2009	TC / MRR
----	---	---------------------------	--	------	----------

2.	<b>Improve access to services</b>	<b>Environment</b>	<ol style="list-style-type: none"> <li>1. Ensure that services are targeted to areas of need when commissioning.</li> <li>2. PCTs must consider dental needs when planning services for new communities.</li> <li>3. Develop access strategies that utilise a joint planning approach with local community groups.</li> <li>4. Map existing provision of dental services against proposed standards and establish process for regular review by September 2008.</li> <li>5. Dental Action Plan to be agreed in consultation with stakeholders, patient, public, what constitutes reasonable access to encompass the maximum distance a patient needs to travel to access services and the maximum waiting time for an appointment.</li> <li>6. Establish and maintain a single point of contact or dental 'portal', eg dental helpline</li> <li>7. Develop multiple access points to dentistry through building effective links with social care, voluntary sector, other primary care health care providers, via local networks.</li> <li>8. PCT to establish the need for extended opening hours and monitor provision regularly.</li> <li>9. PCT to establish the need for out of hours dental care and monitor provision regularly.</li> <li>10. Ensure out of hours services are accessible, eg physical location shared with medical OOH services, appropriate triage, extended opening hours in high street services.</li> </ol>	<p>2009</p> <p>2009</p> <p>2009</p> <p>2009</p>	<p>JW / DS</p> <p>JW / DS</p> <p>JW / DS</p> <p>AC</p>
		<b>Lifestyle</b>	<ol style="list-style-type: none"> <li>1. Encourage health-seeking behaviour in the population, eg visiting dentist, taking children to visit dentist and consenting to school screenings and oral health promotion interventions.</li> <li>2. Consider regular communications to patient and public fora.</li> <li>3. Improved access to information for patients, eg advertisements in Yellow Pages.</li> </ol>		

2.	<b>Improve access to services</b>	<b>Services</b>	<ol style="list-style-type: none"> <li>1. PCTs must commission dental services to meet SHA access targets: <ul style="list-style-type: none"> <li>• A minimum of 60% population to have seen an NHS dentist over last 24 months by 2010-11. Locally this means that Peterborough PCT need to achieve a 15% increase while Cambridgeshire must achieve a 20% increase.</li> <li>• PCTs to establish patient pathways to allow all patients receiving orthodontics in primary care to begin treatment within 18 weeks by April 2010.</li> </ul> </li> <li>2. Provide flexible models of service provision that match the needs of the population, eg mobile units, Dental Access Centres.</li> <li>3. Design patient pathways to ensure appropriate use of secondary and tertiary care services.</li> <li>4. Establish and support development of specialist services eg sedation, patients with special needs, in salaried dental services.</li> <li>5. Establish Referral Management Systems (RMS) to ensure patients receive care in most appropriate setting.</li> <li>6. Evaluate capacity and spread of services for people with special care needs and develop to match population needs.</li> <li>7. Ensure PCT has plans in place to respond to Pandemic Flu.</li> <li>8. Review need for specialist services, eg periodontology and restorative dentistry, and develop services locally.</li> <li>9. Identify and distribute clear information to General Medical Practitioners (GMP) signposting dental services in particular out of hours and emergency care.</li> <li>10. Ensure GMPs have information about appropriate referral pathways eg into secondary care.</li> <li>11. Strengthen the role of the Pharmacy Team in referral pathways to primary dental care.</li> </ol>	<p>2010</p> <p>2010</p> <p>Review 2009</p>	<p>JW / DS</p> <p>JW / AC / SS</p> <p>VC / AC</p>
----	-----------------------------------	-----------------	--	--	---

3.	<b>Improve the experience of service users and empower local communities</b>	<b>Environment</b>	<ol style="list-style-type: none"> <li>1. Work with community partners to improve experience of services users.</li> <li>2. Ensure regular engagement with public and patients.</li> <li>3. Ensure that oral health needs are considered when patients are being assessed for other care.</li> <li>4. Review the opening hours of dental services to ensure they meet the needs of service users.</li> <li>5. Make practices more family friendly, eg extended opening hours.</li> <li>6. Ensure the availability of advocacy and translation services to dental practices.</li> </ol>		
		<b>Lifestyle</b>	<ol style="list-style-type: none"> <li>1. Identify and tackle barriers to dental care.</li> <li>2. Ensure that there is public input into all dental groups.</li> <li>3. Ensure that people have access to accurate and up-to-date information to enable them to make informed choices about their dental care.</li> <li>4. Make information about dental services available in a form that is acceptable, accessible and familiar to the public.</li> <li>5. Encourage good oral health by making preventive advice easily accessible, eg in non-medical environments.</li> <li>6. Information about patients' rights to NHS dental services is widely disseminated and easily accessible.</li> <li>7. Information about patients' right to complain is widely disseminated and easily accessible.</li> </ol>		

3.	<b>Improve the experience of service users and empower local communities</b>	<b>Services</b>	<ol style="list-style-type: none"> <li>1. Service provision should take account of the oral health needs of vulnerable groups to include: travellers, ethnic minorities, older people, asylum seekers, prisoners, homeless.</li> <li>2. Provide flexible service options, eg Dental Access Centres, dental mobiles.</li> <li>3. Ensure that all local dental services implement user surveys annually and that other, more proactive involvement of users in local practices is developed.</li> <li>4. Ensure Out Of Hours services are accessible and responsive.</li> <li>5. PCTs should regularly undertake mystery shopper exercises.</li> <li>6. Support good information systems, eg dental helpline</li> <li>7. Consider oral health needs of people with long term conditions.</li> <li>8. Investigate capacity of and need for domiciliary services.</li> </ol>	2009	HL
4.	<b>Develop excellent, integrated and appropriate services</b>	<b>Environment</b>	<ol style="list-style-type: none"> <li>1. Ensure workforce is fit for purpose</li> <li>2. Consider population growth when planning</li> </ol>		

4.	<b>Develop excellent, integrated and appropriate services</b>	<b>Services</b>	<ol style="list-style-type: none"> <li>1. Oral health should be considered in all strategy documents.</li> <li>2. Commission high quality services</li> <li>3. Support the development of quality dental services eg by use of the PCC clinical governance toolkit.</li> <li>4. Support ongoing training for the dental team eg in IOTN, making referrals, minor oral surgery.</li> <li>5. Consider clinical governance sessions allocation for practices.</li> <li>6. Monitor spread of treatment bands being provided locally.</li> <li>7. Monitor the pattern of recall intervals on general dental practice and promote use of NICE guidance on recall intervals.5.Implement the use of annual user surveys.</li> <li>8. Develop orthodontic and oral maxillofacial surgery referral pathways.</li> <li>9. Consider appropriateness of CDS/DAC balance in salaried services.</li> <li>10. Consider secondary to primary care shift, where appropriate.</li> <li>11. Enable 18 week waiting targets in secondary care to be achieved.</li> <li>12. Enable 18 week waiting targets for referral for dental treatments under general anaesthesia to be achieved.</li> <li>13. Develop anxiety management services to include conscious sedation.</li> <li>14. Develop alternatives to GA eg sedation services</li> <li>15. Reduce numbers of GA and associated waiting times where appropriate in salaried services.</li> <li>16. Promote the early detection and rapid referral of oral cancer.</li> <li>17. Promote access to smoking and alcohol support services.</li> <li>18. Ensure DH decontamination guidance is followed.</li> <li>19. Support regular monitoring of dental practices and dental practice inspections.</li> <li>20. Implement 'Delivering Better Oral Health' in dental practices.</li> <li>21. Improve communications with dentists, eg newsletter.</li> <li>22. Poor performance systems should be in place.</li> </ol>		
----	---	-----------------	---	--	--

5.	<b>Invest resources effectively.</b>	<b>Environment</b>	<ol style="list-style-type: none"> <li>1. Ensure greater geographical equity of services.</li> <li>2. Prioritise investments (WCC).</li> <li>3. Make sound financial investments (WCC).</li> <li>4. Consider new communities when commissioning and planning services.</li> <li>5. Target capital money to support practice development eg IT systems.</li> <li>6. Investment to maintain quality premises eg in decontamination.</li> </ol>		
5.		<b>Services</b>	<ol style="list-style-type: none"> <li>1. Develop dental commissioning strategy based on the oral health strategy.</li> <li>2. Undertake appropriate surveys to ensure services meet the needs of the population.</li> <li>3. Consider appropriateness of CDS/Dental Access Centre balance in salaried services.</li> <li>4. Review specialist services in primary and secondary care.</li> <li>5. Support a secondary to primary care shift where appropriate.</li> </ol>		

6.	<b>Information requirements.</b>	<b>Environment</b>	<ol style="list-style-type: none"> <li>1. Manage knowledge and assess need (WCC).</li> <li>2. Undertake regular epidemiological surveys to establish oral health/health needs of the population.</li> <li>3. Undertake adult dental health survey/patient questionnaire to establish oral health of population.</li> <li>4. Regularly update information on vulnerable groups such as prisoners, travellers, homeless.</li> <li>5. Consider the development of new communities and areas of predicted population growth when planning dental services.</li> </ol>		
		<b>Services</b>	<ol style="list-style-type: none"> <li>1. Consider information needs for effective planning.</li> <li>2. Map services against population as well as deprivation and contract value.</li> <li>3. Continue to undertake epidemiological surveys laid out in Department of Health Public Health Directors to PCTs 2009.</li> <li>4. Evaluate the 2010 Adult Dental Health Survey and its value locally.</li> <li>5. Collect and monitor activity data for primary care, salaried services, secondary and specialist care.</li> <li>6. Consider reintroduction of school screening in areas of high need eg Wisbech and March.</li> <li>7. Consider undertaking annual user surveys.</li> <li>8. Review Business Services Authority, Dental Practice Division data collected through patient satisfaction surveys.</li> <li>9. Regularly review PALs and other data collected through patient and public information fora.</li> <li>10. Ensure clinical audit in secondary care is commissioned to generate information on key strategic health issues.</li> </ol>	2009	CCS

7.	<b>Empowering and working with dental professionals.</b>	<b>Environment</b>	<ol style="list-style-type: none"> <li>1. Regular engagement with GDPs and dental teams.</li> <li>2. Investment to maintain quality premises.</li> <li>3. Consider GDP representation on relevant groups eg PEC, OHAG.</li> <li>4. Support the development of enhanced training practices.</li> </ol>		
		<b>Lifestyle</b>	<ol style="list-style-type: none"> <li>1. Support training for dental teams (nurses, VDPs).</li> <li>2. Provide training for dental teams to develop their health promoting knowledge and skills.</li> <li>3. Develop role of dental care professionals in delivering high quality health promotion.8. Consider top up training for poor performers/equivalence.</li> <li>4. Train dental teams to routinely examine the oral mucosa of all patients.</li> <li>5. Support training and support for dental teams in the recognition of children at risk of non-accidental injuries.</li> <li>6. Consider training GPs to undertake examination of the oral mucosa of tobacco users, heavy drinkers and older people.</li> <li>7. Encourage and train pharmacists to recognise oral health problems that need referral to dentist or specialist care.</li> </ol>		
		<b>Services</b>	<ol style="list-style-type: none"> <li>1. Lead continuous and meaningful engagement with clinicians to inform strategy and drive quality service design and resource utilisation (WCC).</li> <li>2. Develop opportunities to work with dental teams to further promote health and oral health in practice.</li> <li>3. Consider development of support system and integrated working, currently available to GPs, for GDPs.</li> <li>4. Encourage more integration of dental teams with PCT.</li> <li>5. Support and develop clinical audit and peer review in dental practice.</li> <li>6. Support practices to implement 'Delivering Better Oral Health'.</li> <li>7. Support continued professional development.</li> </ol>		

## 4. REFERENCES

- 4.1 Choosing Better Oral Health, An Oral Health Plan for England 2005  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4123251](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123251)
- 4.2 The NHS Operating Framework 2008/2009.  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_081094](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094)
- 4.3 Commissioning NHS Primary Care Dental Services: meeting the NHS Operating Framework January 2008.  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_082104](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082104)
- 4.4 Delivering Better Oral Health: An evidence-based toolkit for prevention 26 September 2007 Gateway reference 8504.  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_078742](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078742)
- 4.5 HM Government Health and Social Care (Community Health and Standards) Act 2003. Chapter 43 HMSO London  
<http://www.opsi.gov.uk/acts/acts2003/20030043.htm>
- 4.6 NHS East of England (Strategic Health Authority): Improving Lives; Saving Lives.  
[http://www.eoe.nhs.uk/page.php?page\\_id=60](http://www.eoe.nhs.uk/page.php?page_id=60)

## 5. GLOSSARY OF TERMS

**Common risk factor approach (CRFA):** An approach to promoting general health by controlling a small number of risk factors which can have a major impact on a large number of diseases. This is a cost-effective alternative to disease-specific approaches.

**Dental Care Professionals (DCPs):** This term commonly refers to members of the wider dental team, such as dental therapists, hygienists, and dental nurses.

**Dental caries:** The material remaining after tooth substance has been destroyed as a result of attack by acids produced by plaque bacteria from sugars in the diet. Commonly referred to as tooth decay.

**Dental trauma:** Tooth loss or damage caused by physical injury.

**DMFT/dmft:** An indicator of the level of dental decay obtained by calculating the number of decayed, missing and filled teeth (dmft score). DMFT refers to decay experience in the permanent or secondary dentition and dmft to the decay experience in the primary dentition. The average score is reported for a population.

**Erosion:** Chemical dissolution of teeth.

**Fissure sealants:** A plastic-like material placed in the grooves and pits of the biting surfaces of the back teeth to prevent decay starting in these susceptible sites.

**Fluoride:** A chemical compound that helps to prevent dental caries.

**GDP:** General Dental Practitioner.

**NICE:** National Institute for Health and Clinical Excellence. [www.nice.org.uk](http://www.nice.org.uk)

**Oral cancer:** Malignant tumour of the mouth.

**Oral health:** A standard of health of the oral and related tissues which enables an individual to eat, speak and socialise without active disease, discomfort or embarrassment and which contributes to general wellbeing (Department of Health, 1994).

**Oral mucosa:** The mucous membrane lining the mouth.

**Periodontal disease:** Disease of the gums and supporting structures of the teeth. Commonly referred to as gum disease.

**ppm:** Parts per million, eg of fluoride. A measure used to denote the fluoride content of toothpaste and mouthwashes.

**Water fluoridation:** Addition of fluoride to a population's drinking water to reduce tooth decay. Fluoride may be added to other substances eg milk, toothpaste.

**This page has been left intentionally blank**