LEICESTERSHIRE, LEICESTER AND RUTLAND HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 16 NOVEMBER 2021

UPDATE PAPER ON NHS DENTAL SERVICES IN LEICESTER, LEICESTERSHIRE AND RUTLAND

REPORT OF: NHS ENGLAND AND IMPROVEMENT (NHSEI) – MIDLANDS

Purpose of the Report

1. The purpose of this report is to provide an update to the committee on the provision of NHS dental services commissioned in Leicester, Leicestershire and Rutland (LLR). The report will include an overview of the ongoing effects of the COVID-19 pandemic and the steps being taken to restore and recover service provision.

Background

Access to services

2. It is important to clarify that NHS dental care, including that available on the high street (primary care), through Community Dental Services or through Trusts is delivered by providers who hold contracts with NHS England and NHS Improvement. All other dental services are of a private nature and outside the scope of control of NHSEI. The requirement for NHS contracts in primary and community dental care has been in place since 2006.

3. There is no system of patient registration with a dental practice. People with open courses of treatment are practice patients during the duration of their treatment, however once complete; apart from repairs and replacements, the practice has no ongoing responsibility. People often associate themselves with dental practices. Many dental practices may refer to having a patient list or taking on new patients, however there is no registration in the same way as for GP practices and patients are theoretically free to attend any dental practice that will accept them. Dental statistics are often based on numbers of patients in touch with practices within a 24-month period and this in many cases be based on repeat attendances at a “usual dentist”.

4. General Dental Practices within Leicester, Leicestershire and Rutland offer a range of routine dental services; some of these generalist providers also provide less complex orthodontic services. In addition, there are specialist Orthodontic practices; the orthodontists in these practices are specialists and provide more complex care. Extended or out of hours

cover is provided by five 8-8 contracts, services which provide access to patients 8am – 8pm 365 days of the year for both routine and urgent care. Secondary care is provided by University Hospitals of Leicester (UHL) and Community Dental Services for special care adults and children is provided from five clinics in the area by CDS-CIC.

5. Around 50% of the population are routinely in touch with NHS high street dental services; the numbers of people attending private services is not known; but is not expected to be the remaining 50% of the population. Many people with less structured lifestyles or who are vulnerable may not engage with routine care and may instead use unscheduled/out of hours dental services. Individuals are free to approach practices to seek dental care and further information on NHS dental practices is available on the NHS website: https://www.nhs.uk/service-search/find-a-Dentist.

Timeline of National pandemic response and impacts upon dentistry

6. A timeline of the key decisions taken nationally and the impact upon dentistry is included below:

- ***March 23rd, 2020***
  Routine dental services in England were required to close. Providers continue to receive contractual payments as previously (with a 16.75% abatement to mitigate cost savings of closure).

  All staff are required to be paid as per previous arrangements and providers instructed to operate remote telephone access for any patient contacting the practice.

- ***April 2020***
  NHSEI commissions and mobilises Urgent Dental Centres (UDCs) to ensure that patients with urgent needs can continue to access treatment. Dental practices are obliged to provide remote triage and advice, the prescription (where appropriate) of analgesia and antibiotics despite being 'closed' as per an Urgent Care Standard Operating Procedure (SOP).

  UDCs are mobilised in Leicester City (Nelson street), Melton Mowbray, Loughborough and Oakham. Post analysis of patient referrals and usage, the UDC in Oakham is stood down and a further UDC site in Hinckley is mobilised in June 2020.

  The Urgent Dental Centres remain open and operational and continue to operate at the time of writing to provide urgent care access and treatment for patients across LLR.

- ***June 8th, 2020***
  NHS Dental practices are allowed to reopen, with strict Infection Prevention Control (IPC) and social distancing protocols outlined and implemented. NHSEI supports practices to reopen as swiftly as possible.

- ***June 30th, 2020***
  An additional period of "lockdown" is enforced in Leicestershire. This decision taken by government to mitigate the impact of a rise in COVID-19 cases.

  During the Leicester and Leicestershire incident and restrictions, UDCs continued to provide access to patients requiring emergency treatments.

  General dental practices are supported to undertake rigorous risk assessments to ensure that, wherever possible, practices remain open and able to provide access to patients.

  A vast majority of Leicester and Leicestershire practices in affected areas remain open and continue to provide access to patients. Those that are unable to remain open are supported to re-open as soon as possible and are mandated to provide remote triage to all patients that contact the practice (referring onwards to a UDC if necessary).

- ***July 20th, 2020***
  All dental practices are expected to reopen and recommence provision of face-to-face services. Any practice advising that they are unable to reopen are contacted to understand the barriers to reopening and to support the development of an action plan to reopen as soon as possible.

- ***January – March 2021***
  General dental providers are required to deliver a minimum threshold of 45% of their pre-COVID Units of Dental Activity (UDA) or 70% of their pre-COVID Units of Orthodontic Activity (UOA) in order to continue to receive 100% payment of their contract.

  The minimum thresholds are not designed as 'targets' and are based upon the impact of providers adherence to the IPC and social distancing guidance imposed nationally.

  Providers advised to inform NHSEI immediately as to any circumstances which may limit their achievement of these minimum thresholds so that arrangements can be put into place to support service recovery.

  Failure to achieve the minimum threshold of activity to result in a clawback of funding paid to providers upon reconciliation and review of activity.

- ***April 2021 – September 2021***
  Required minimum thresholds for contract delivery are increased to a minimum of 60% of UDAs for general dental providers and 80% of UOAs for orthodontic providers, in order for providers to continue to receive 100% payment of their contract.

  The thresholds are to remain constant for Quarters 1 & 2 of 2021/22 to provide stability to providers as they continue to recover services.

Failure to achieve the minimum threshold of activity results in a clawback of funding paid to providers upon reconciliation and review of activity.

- ***October 2021 – December 2021***
  Required minimum thresholds for contract delivery are increased to a minimum of 65% of UDAs for general dental providers and 85% of UOAs for orthodontic providers in order to continue to receive 100% payment of their contract.

  Minimum thresholds are increased owing to some flexibility in IPC guidance which allows practices to treat patients with less 'downtime' between appointments.

  IPC guidance and contractual minimum thresholds are to be revisited and reassessed in the coming weeks, with the minimum thresholds for January 2022 – March 2022 communicated in due course.

Ongoing impact and effects of the COVID-19 Pandemic.

7. The ongoing COVID-19 pandemic has had a considerable impact on dental services and the availability of dental care. The long-term impact on oral health is as yet unknown but forms a key component of recovery and restoration work being undertaken by NHSEI.

8. A significant constraint, that has limited practices in their ability to offer increased patient access and treatment, has been the introduction of 'downtime' – a period of time for which the surgery must be left empty following any aerosol-generating procedure (AGP). An AGP is a procedure that involves the use of high-speed drills or instruments and would include fillings, root canal treatment or surgical extractions. This has had a marked impact on the throughput of patients.

9. The constraints on the amount of activity that practices are able to safely deliver has dictated that NHS dental care remains prioritised towards those in greatest need. Primarily, during the pandemic, this has referred to patients with an urgent need for dental assessment and treatment.

10. NHSEI has worked closely with providers and other stakeholders to develop an Outbreak Standard Operating Procedure for practices to report any staff members that are self-isolating or have received positive COVID-19 tests. NHSEI is committed to supporting practices where incidents occur but can confirm that service delivery impacts have been minimal and are being well managed by practices across LLR.

Urgent Dental Centres (UDCs) and the Urgent Care pathway

11. Urgent and emergency oral and dental conditions are those likely to cause deterioration in oral or general health and where timely intervention for relief of oral pain and infection is important to prevent worsening of ill health and reduce complications (SDCEP, 2013). Urgent dental care problems have been defined previously into three categories (SDCEP,

2007). The table below shows current national information about the 3 elements of dental need and best practice timelines for patients to receive self-help or face to face care.

Triage Category	Time Scale
Routine Dental Problems	Provide self-help advice. Provide access to an appropriate service within 7 days if required. Advise patient to call back if their condition deteriorates
Urgent Dental Conditions	Provide self-help advice and treat patient within 24 hours. Advise patient to call back if their condition deteriorates
Dental Emergencies	Contact with a clinician within 60 minutes and subsequent treatment within a timescale that is appropriate to the severity of the condition

12. UDCs and Out of Hours services have been set up to operate to provide care in line with the standards described above. Practices also apply the same criteria but routine dental problems (those not associated with significant pain or swelling) are unlikely to be deliverable currently within 7 days due to the need to prioritise those in pain.

13. The availability of routine check-ups remains likely to be limited to those who are vulnerable or who have ongoing dental issues, however the number of providers 'recalling' patients for routine check-ups and treatments continues to increase across the Midlands.

14. Many patients with generally good oral health would not be expected to require 6 monthly check ups under normal circumstances and these remain safe to be deferred at this time. Treatment options may be more limited than usual. This is due to the need for AGP (aerosol generating procedures) for restorative dentistry (e.g. fillings and root canals) which are limited due to the extended 'downtime' necessary between patients.

15. At the outset of the pandemic response, the dental team engaged with stakeholders (including the Local Dental Committee (LDC), Local Dental Network (LDN) and PHE colleagues) to agree suitable sites for urgent dental care centres.

16. Across Leicester, Leicestershire and Rutland (LLR) initial sites were mobilised in Leicester City (Nelson Street), Loughborough, Melton Mowbray and Oakham. These sites were all established 8-8 practices, which offered the optimum combination of geographical coverage, contracted hours of opening and staffing.

17. Post analysis of patient access and geographical location of patients accessing the UDCs, the decision was taken to stand down the service at Oakham in order to mobilise an additional site in Hinckley, thus providing better access for patients in the west of the county. Hinckley remains an operating UDC along with sites in Leicester City, Loughborough and Melton Mowbray.

18. In addition, sites were mobilised to provide care for those vulnerable patients that were "shielding" and for symptomatic patients. The local Community Dental Service was mobilised to provide these services, with

enhanced infection prevention control measures in place for patients attending the symptomatic site.

19. The local Community Dental service continues to provide care for those with special care needs including some children.

20. The UDCs remain operational and continue to support other local practices in providing care to local patients – in particular those who do not have a "usual" dentist or are new to NHS dental care.

21. There remains no direct access into the UDCs; they are required to follow distancing and appointment only face to face contacts. Referral to a UDC is via a general dental practice or via 111.

22. The optimum pathway for accessing dental services (whether urgent or routine) remains for patients to contact a local dental practice (when attempting to access care during working hours) or to contact NHS 111 outside of working hours.

Vulnerable patients

23. NHSEI, the Office of the Chief Dental Officer (OCDO), the Department of Health and Social Care (DHSC) and Public Health England have all written to providers to try and ensure that patients from vulnerable groups are not detrimentally impacted by the continued reduced levels of dental service provision.

24. Practices are expected to prioritise vulnerable patients (including children and those most 'at-risk' of dental disease and oral health problems) when recommencing routine care and recalls for check-up appointments.

LLR dental service performance

25. Across LLR during the first six months of the financial year 2021/22, 64.4% (vs. a minimum threshold of 60%) of pre-COVID contracted UDAs was delivered.

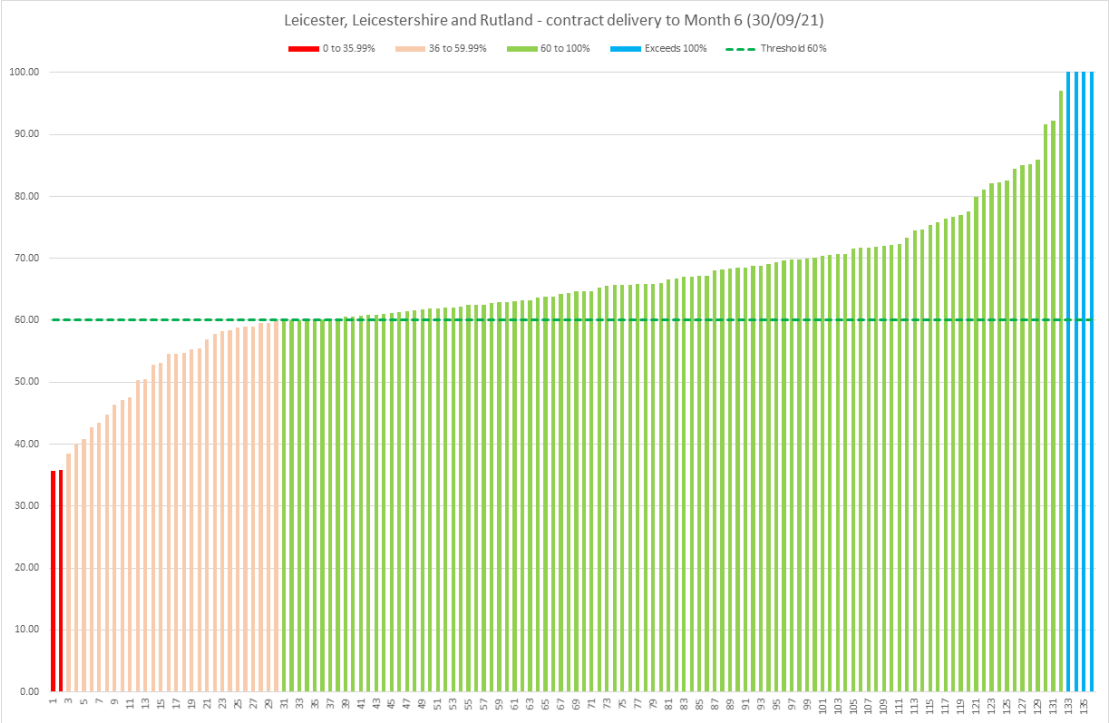
26. This represents a 'loss' of over 300,000 Units of Dental Activity (UDAs) during this period against the levels of pre-COVID activity commissioned by NHSEI and illustrates the level of service impact that the pandemic continues to have upon dental services.

    However it is also important to note that one UDA does not equate to one appointment of course of treatment as different treatments attract different levels of UDAs (i.e. the more complex a course of treatment, the more units the course of treatment attracts to ensure that providers are compensated for the increased amount of time and resource required for that treatment).

27. During April-September 2021 (Q1 & Q2) providers were required to deliver a minimum of 60% of their pre-COVID contractual activity, in order to

continue to receive 100% payment. Figure 1 (below) illustrates this achievement for all LLR providers during this time period.

Figure 1: LLR provider delivery Apr-Sep 2021



28. Of the 136 contracts in LLR providing general dental services:

- 2 contracts (red) delivered less than 36%
- 28 contracts delivered between 36% - 60%
- 102 contracts delivered between 60% - 100%
- 4 contracts delivered greater than 100% (i.e. greater than the level of activity commissioned by NHSEI)

29. For Orthodontic providers the minimum threshold is higher (owing to less complex IPC guidance and less frequent use of AGPs) at 80%. During Q1 and Q2 across LLR providers delivered 86.9% of contracted orthodontic activity.

30. All providers delivering less than 60%/80% of activity are subject to contractual action by NHSEI. NHSEI will reclaim the appropriate proportion of monies paid to under-performing providers and reinvest these monies in schemes designed to support service recovery.

Recovery and Restoration of services

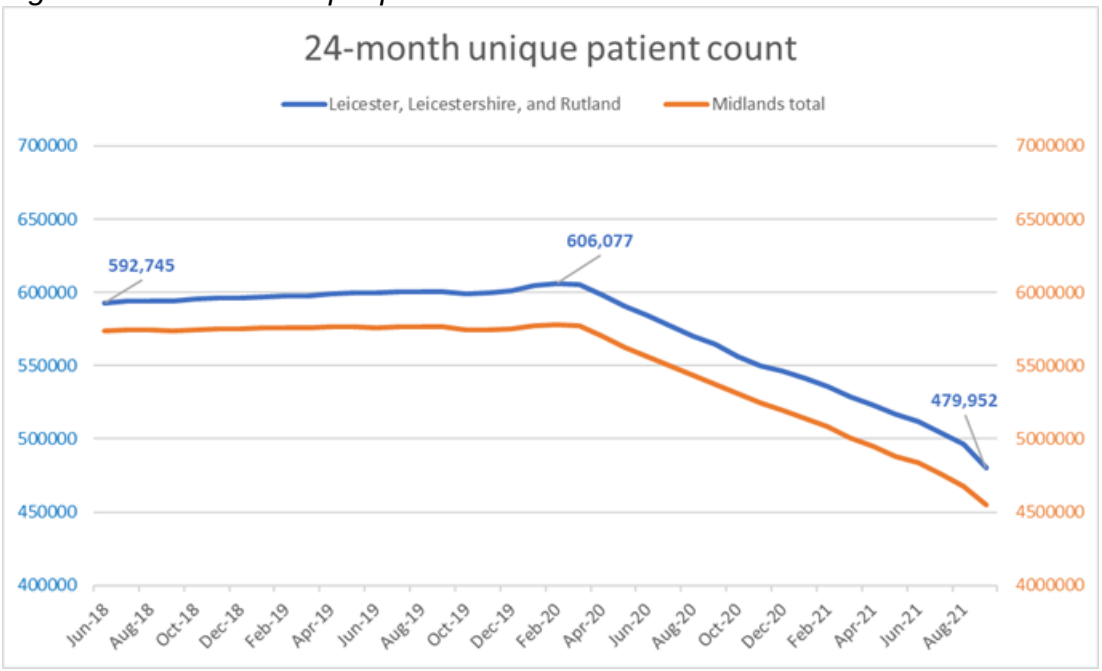
31. Outlining a timeframe for full service recovery remains difficult, owing to the continued requirement for enhanced IPC measures and the impacts upon providers and their staff of the pandemic thus far.

32. The most appropriate objective measure to illustrate the 'loss' of activity is in the shape of 24-month unique patient access figures. These figures show the number of patients accessing NHS dental services over a two-

year period. While this measure is not perfect (as some patients may be more likely to visit a dentist in this timeframe and others may not ordinarily visit at all) it does provide a proxy measure for 'lost appointments' and demonstrates the scale of the service backlog that exists.

33. Figure 2 (below) shows the impact of the COVID-19 pandemic on the 24-month unique patient count for both LLR and the Midlands region:

Figure 2: LLR 24m unique patient count



34. Broadly speaking, the above chart illustrates that, across LLR, there are approximately 126,125 patients that would ordinarily visit a dentist that have been unable to do so during the last eighteen months or so. Before dentistry can be fully 'restored' to pre-pandemic levels, this backlog will need to be addressed.

NHS England and Improvement initiatives

35. To support the recovery and restoration of dental services, NHSEI has commissioned additional initiatives across the Midlands to attempt to mitigate the detrimental impact upon dental access and the limitations upon providers in delivering maximum numbers of appointments.

Weekend Access scheme

36. NHSEI opened an expression of interest to all dental providers across the region to provide additional sessions of activity outside of contractual hours at weekends. This initiative was designed to encourage providers to open for additional sessions and appointments and increase patient provision.

37. Criteria were developed to ensure that activity commissioned was additional and that providers were only eligible if they were able to deliver their contracts in line with national minimum thresholds. Providers were also required to pass clinical checks to ensure that activity commissioned was of a high and safe standard for patients.

38. The initiative was initially offered to providers during January – March 2021; 152 additional sessions were commissioned from 4 providers across LLR. This represents an additional 1500 UDAs.

39. Following the success of the scheme it was repeated with providers able to deliver sessions during the period July 2021 – March 2022. 14 providers across LLR submitted applications which met the criteria and an additional 460 sessions have been commissioned. This represents approximately an additional 5520 UDAs.

Ventilation schemes

40. A key input towards the restoration and recovery phase of NHS Dental services is the ability to increase patient access and treatment by reducing post AGP 'downtime' by supporting NHS dental practices to understand their air changes per hour (ACH) and 'downtime' whilst meeting the Workplace (Health, Safety and Welfare) Regulation.

41. To assist providers in operating as efficiently as possible NHSEI commissioned support via a contribution to practices to undertake a basic ventilation and filtration survey. This helped providers to understand their current building ventilation and filtration and how this can be enhanced to maximise throughput.

42. Across LLR seven providers have received funding to improve the ventilation in their practice and to reduce the required 'downtime' between AGP appointments.

Dedicated 111 slots

43. NHSEI recognises the impact of the pandemic on dental access and particularly the accessing of care by vulnerable groups. Many vulnerable groups access services infrequently and only when their needs are of an urgent nature.

44. To support this cohort of patients, NHSEI engaged with providers and NHS 111 to secure an additional 56 appointments per week across LLR, to be accessed and booked via NHS 111, for patients that do not regularly attend a dental practice.

45. Providers are required to reserve these appointments and to ensure that they are utilised only for the patients in this cohort, who access the dental pathway via 111 and meet the criteria for urgent treatment.

46. Review of the initiative is ongoing but all parties have reported a good level of usage and treatment of patients that fit the vulnerable criteria, with no slot wastage as any unused slots are offered for patients who contact the practice directly should a slot not be booked by 111.

47. It is hoped that this ongoing initiative will ensure access to services for those patients that do not ordinarily engage with dental services, via a direct and expedited route.

New appointments

48. To ensure that NHS Dental services are at the forefront of the new Integrated Care Systems NHSEI has newly appointed Steve Claydon as the Local Dental Network (LDN) Chair for LLR. Steve's role will be ICS-facing and provide a direct senior clinical link between NHSEI and the ICS and other stakeholders, including the JHOSC meeting.

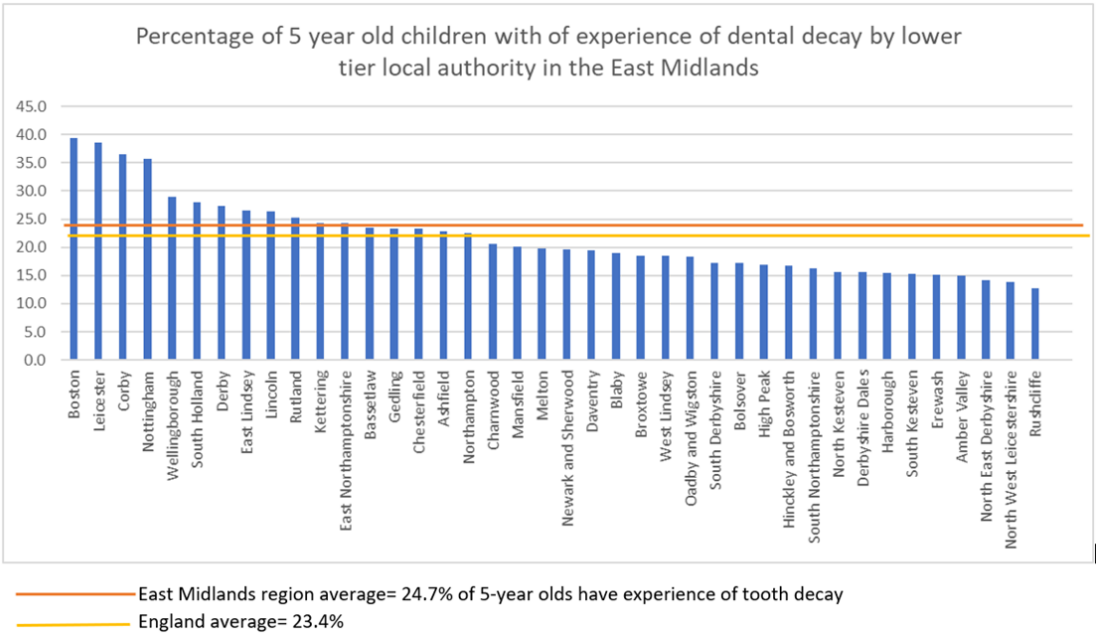
49. In addition, Adam Morby has been appointed as the Midlands Regional Chief Dental Officer, to provide senior clinical leadership for dentistry across the region and a greater link to the chief dental officer for England and the DHSC.

Oral health in Leicester, Leicestershire and Rutland

Child oral health

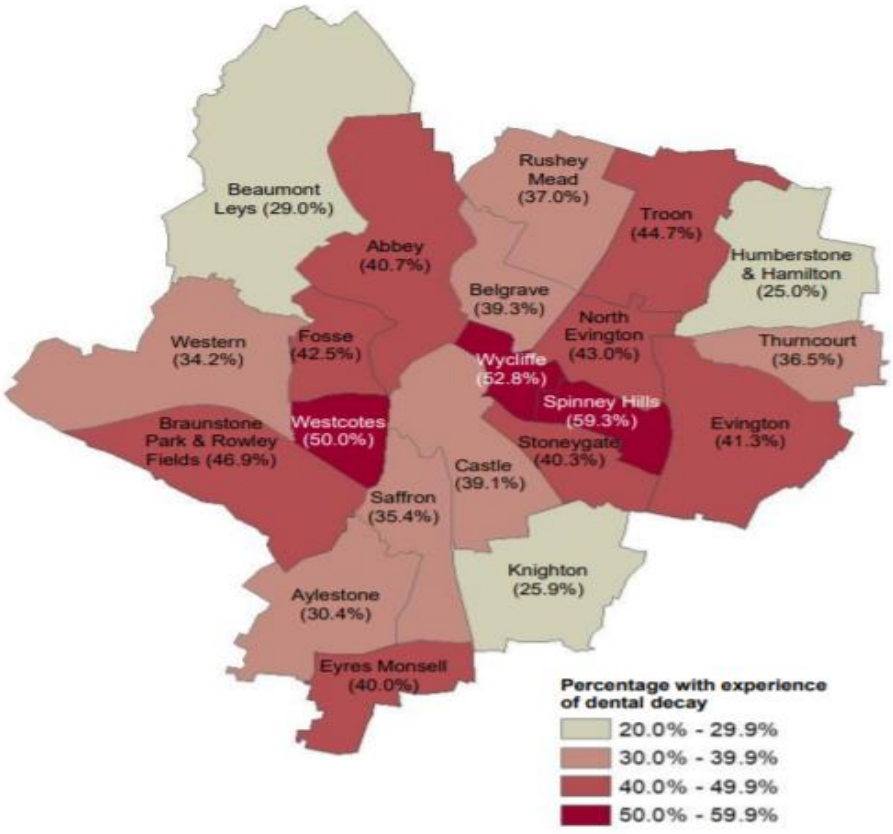
50. The national child dental epidemiology programme conducts a survey of the dental health of 5-year-old state school pupils every two years. The most recent survey published at the start of 2021 shows that:

- in Leicester city, childhood tooth decay levels are the second highest in the region.
- Within Rutland, child decay is slightly higher than the regional and national average.
- In Leicestershire, Charnwood district has the highest tooth decay rates in the county.



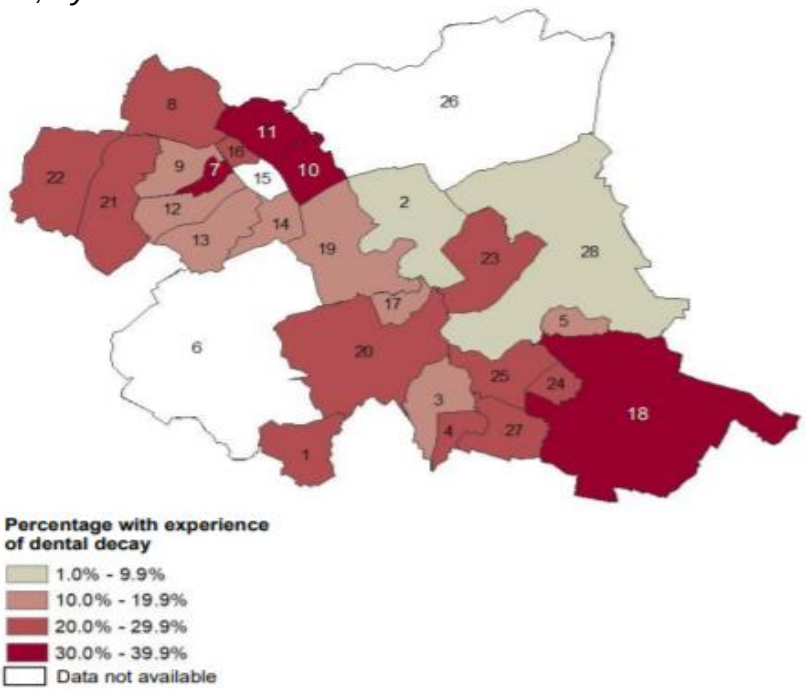
51. In Leicester average levels of dental decay are higher than the average for England. Within Leicester there are areas where there are higher than average levels of experience of dental decay. At ward level, children living in Westcotes, Wycliffe and Spinney Hills have the highest levels of experience of dental decay. Within the school health profile areas, the highest levels of experience of dental decay are clustered around Central, West and North

Figure 3: Prevalence of experience of dental decay in 5-year-olds in Leicester, by ward



52. In Leicestershire average levels of dental decay are lower than the average for England. However, within Leicestershire there are areas where there are higher than average levels of experience of dental decay. At lower-tier local authority level, children living in Charnwood have the highest levels of experience of dental decay. Within Charnwood, the highest levels of experience of dental decay are clustered around the wards of Loughborough Ashby, Loughborough Hastings, Loughborough Lemyngton and Queniborough.

Figure 4: Prevalence of experience of dental decay in 5-year-olds in Charnwood, by ward

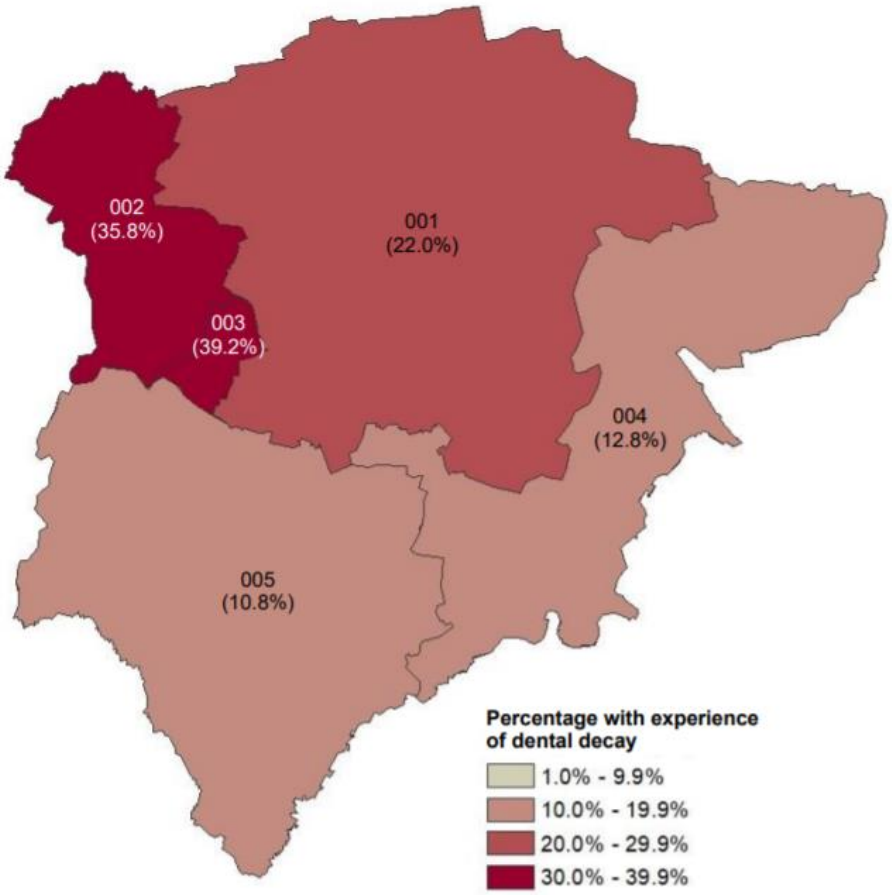


Key	Label
1	Anstey (24.0%)
2	Barrow and Sileby West (4.5%)
3	Birstall Wanlip (15.7%)
4	Birstall Watermead (24.1%)
5	East Goscote (11.1%)
6	Forest Bradgate
7	Loughborough Ashby (33.3%)
8	Loughborough Dishley and Hathern (27.0%)
9	Loughborough Garendon (16.7%)
10	Loughborough Hastings (33.3%)
11	Loughborough Lemyngton (38.2%)
12	Loughborough Nanpantan (16.7%)
13	Loughborough Outwoods (19.0%)
14	Loughborough Shelthorpe (15.4%)

Key	Label
15	Loughborough Southfields
16	Loughborough Storer (26.3%)
17	Mountsorrel (14.8%)
18	Queniborough (33.3%)
19	Quorn and Mountsorrel Castle (19.0%)
20	Rothley and Thurcaston (22.9%)
21	Shepshed East (28.0%)
22	Shepshed West (27.5%)
23	Sileby (20.6%)
24	Syston East (27.3%)
25	Syston West (22.6%)
26	The Wolds
27	Thurmaston (26.7%)
28	Wreake Villages (6.3%)

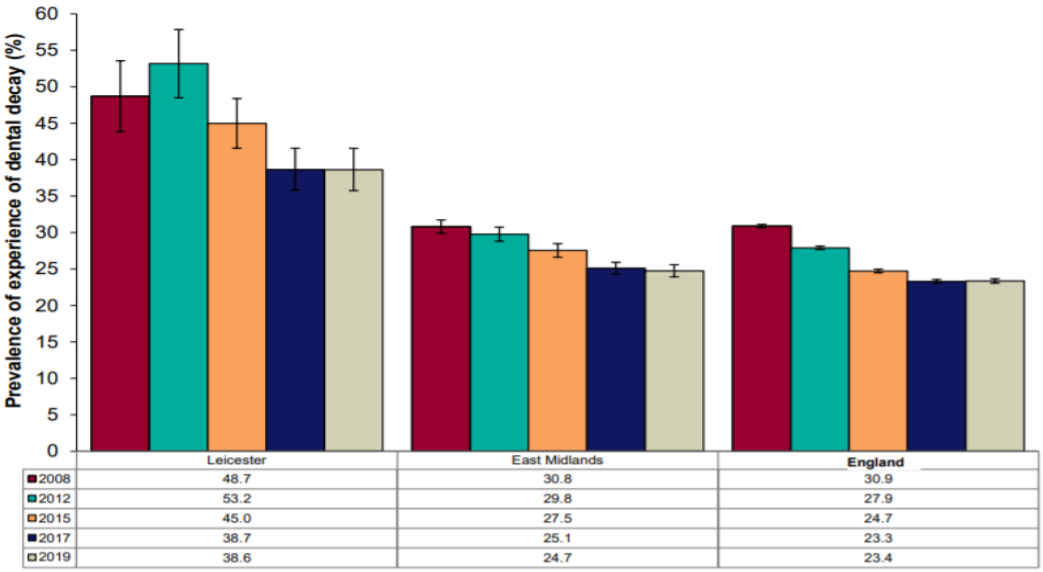
53. In Rutland average levels of dental decay are higher than the average for England. Within Rutland there are areas where there are higher than average levels of experience of dental decay. At a Middle Super Output Area (MSOA) level, children living in MSOA 002 and MSOA 003 have the highest levels of experience of dental decay.

Figure 5: Prevalence of experience of dental decay in 5-year-olds in Rutland, , by middle layer super output area (MSOA)



54. Despite these higher than average levels of child dental decay in Leicester city, rates have fallen considerably over the past decade in both city and county, reflecting national and local oral health improvement efforts.

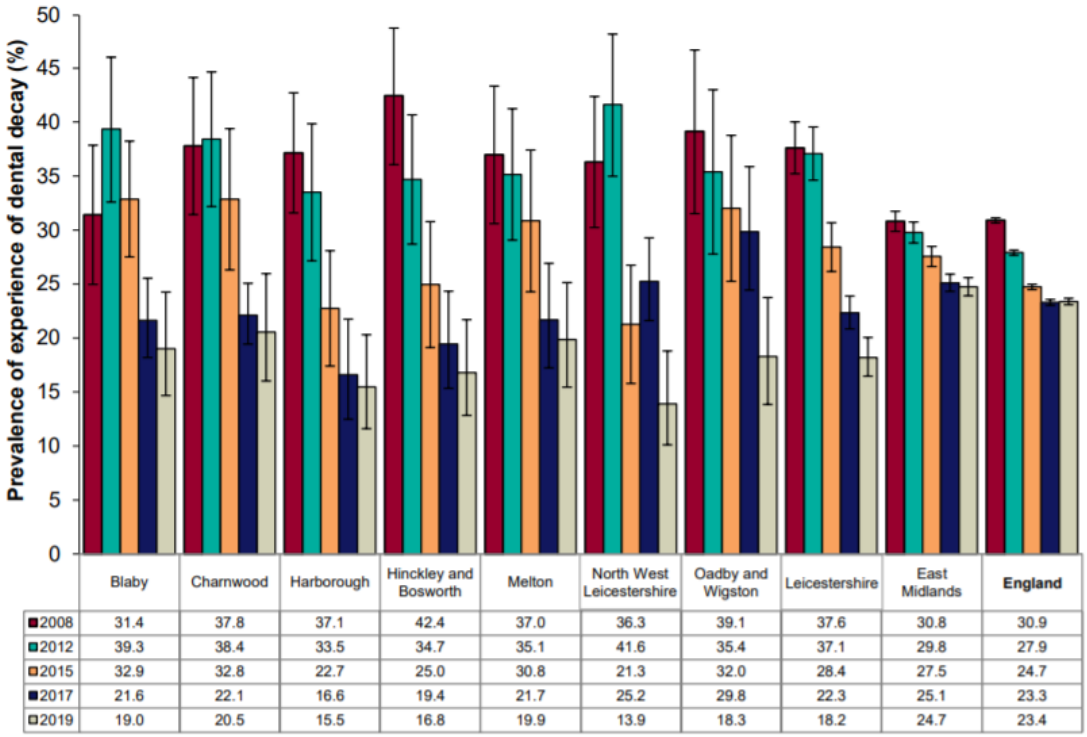
Figure 6: Prevalence of experience of dental decay (%)



	Leicester	East Midlands	England
2008	48.7	30.8	30.9
2012	53.2	29.8	27.9
2015	45.0	27.5	24.7
2017	38.7	25.1	23.3
2019	38.6	24.7	23.4

Error bars represent 95% confidence limits

Figure 7: Prevalence of experience of dental decay (%)



	Blaby	Charnwood	Harborough	Hinckley and Bosworth	Melton	North West Leicestershire	Oadby and Wigston	Leicestershire	East Midlands	**England**
2008	31.4	37.8	37.1	42.4	37.0	36.3	39.1	37.6	30.8	30.9
2012	39.3	38.4	33.5	34.7	35.1	41.6	35.4	37.1	29.8	27.9
2015	32.9	32.8	22.7	25.0	30.8	21.3	32.0	28.4	27.5	24.7
2017	21.6	22.1	16.6	19.4	21.7	25.2	29.8	22.3	25.1	23.3
2019	19.0	20.5	15.5	16.8	19.9	13.9	18.3	18.2	24.7	23.4

Error bars represent 95% confidence limits

Prevention of child dental disease in LLR

55. LLR has a well-established and very active Oral Health Strategy Group, jointly led by the local authorities and consisting of system-wide partners across health and social care, with the input of specialist dental public health advice through the former Public Health England (recently transitioned into NHS England). This multiagency partnership group develop strategic plans around oral health improvement for all LLR residents across the lifecourse, informed by undertaking a joint oral health needs assessment of the population, which is regularly updated as new data becomes available. The local authorities commission dedicated oral health promotion services who engage with and visit schools across LLR to deliver oral health promotion and prevention.

56. Priorities and actions for the group in tackling child dental decay include:

- Increasing access to supervised toothbrushing in nursery and school settings, and increasing access to fluoride across the region (via toothpaste distribution and topical varnish applications), particularly targeted to those areas that do not enjoy the benefits of water fluoridation

- Working with health visitors and community workers to better identify children and their families who are at high risk of tooth decay and poor oral health so that preventative advice, support and signposting to available services can be actioned, thus contributing to a reduction in the number, and associated financial, social and personal burden, of

children having to attend hospital for tooth extractions under general anaesthetic.

- Working with NHSEI dental commissioners to improve access to child dental services, both at primary and community dental care levels across the county, targeted at areas of highest need wherever possible, and engaging with general dental practices to upscale and enhance their delivery of evidence-based prevention activities

57. NHSEI dental commissioning, public health and the local authority co-design and fund a range of evidence-based prevention interventions and initiatives to improve child and adult oral health and mitigate against the recognised risks to oral health with further funding being made available to mitigate against the effects of the pandemic on dental services.

    With the recent government White Paper of healthcare reform plans to take central government control in relation to the future expansion of community water fluoridation schemes, to help remove some of existing barriers to this, we would recommend wider political advocacy and support at a local level for the introduction of water fluoridation across LLR, as this would be a significant positive and highly cost-effective intervention in reducing the inequalities in child dental health.

Adult oral health and prevention in LLR

58. In 2017/18 the National Dental Epidemiology Programme undertook an oral health survey of adults attending general dental practices in England. It provided data to inform joint strategic needs assessments and oral health needs assessments to plan and commission oral health improvement interventions and services for adults.

    Adults attending general dental practices for any reason, aged 16 years and over, were recruited to take part in the survey. The survey consisted of a questionnaire on the impact of oral problems on individuals, use of dental services and barriers to receipt of care and a brief clinical examination conducted by trained local epidemiology teams under standardised conditions.

59. Summary of adults' oral health for LLR

- the oral health of adults has improved significantly over the last 40 years with more of the population retaining their natural teeth throughout life

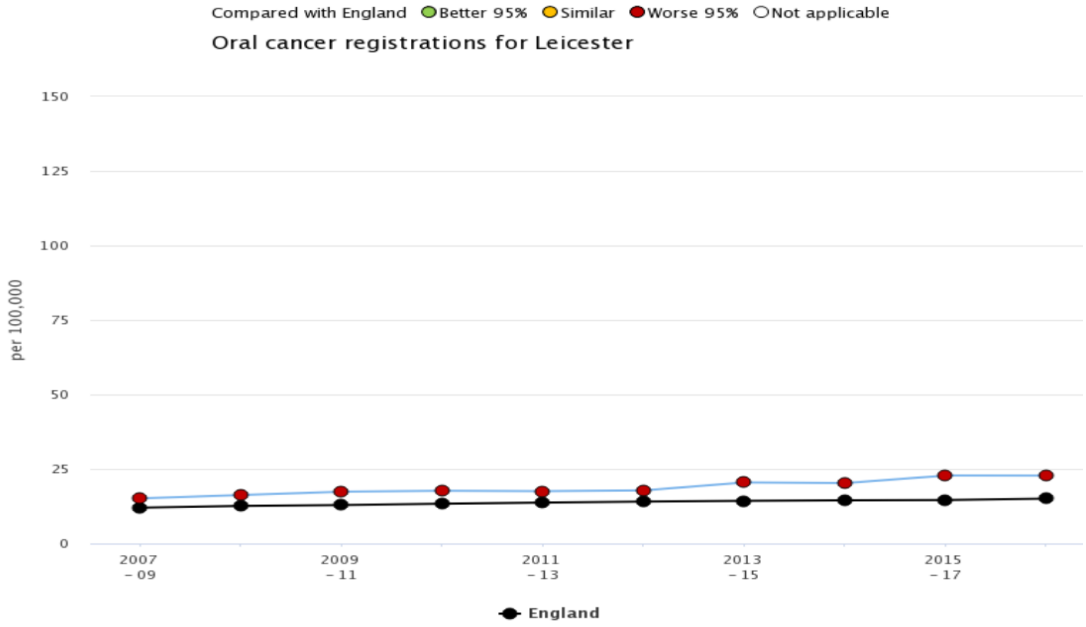
- in Leicester 36.4% of adults had tooth decay, compared with 28% nationally, and 2% had severe gum disease. 84% of adults in the city had an identified dental treatment need-compared to around 70% nationally, with around 2% classed as urgent need. Around 11% of adults in Leicester had not seen a dentist within the last 2 years, compared with a national figure of 8% of adults. Corresponding levels for Leicestershire and Rutland were lower than the national averages across all these indicators

- men from materially deprived backgrounds were more likely to experience higher levels of tooth decay and gum disease but least likely to visit a dentist.

Oral cancer in Leicester

60. Oral cancer diagnosis and death rates in Leicester are consistently and significantly higher than the national average. The latest data shows national oral cancer new registration rates at 15 per 100,000 populations, whereas in Leicester, this was around 23 per 100,000

Figure 8: Oral cancer registations



61. The main risk factors for oral cancer are age, current or previous tobacco and alcohol use, with risk increasing greatly with increasing levels of exposure to these, and poor diet. Many oral cancers are diagnosed at a late stage and where there is a poor survival rate.

    Leicester has the second worst death rates from oral cancer in the country (mortality rate of 9.2 per 100,000, almost double that seen nationally), which indicates that too many oral cancers are being diagnosed too late. Dentists are the main diagnostic route to referral with many cases picked up at routine check-up appointments, as well as GPs, so there is a risk that the impact of the pandemic on access to dental services will have led to cancers not being detected with subsequent poorer patient outcomes.

62. Delivery of effective lifestyle advice and Making Every Contact Count (MECC) initiatives to help people quit tobacco use and reduce alcohol consumption is a key prevention tool in tackling rising rates of oral cancer, along with training for all healthcare professionals and the public on the importance of early identification and diagnosis. Over the past number of years, the public health team has had a programme of education and training activities working with the local authority, the NHS and cancer

charities within Leicester and wider to raise awareness and upskill the workforce around MECC and oral cancer.

Epidemiology of oral diseases in vulnerable groups

63. Vulnerable groups are those people whose economic, social, environmental circumstances or lifestyle place them at high risk of poor oral health or make it difficult for them to access dental services. This includes people who are old and frail, have physical or mental disabilities, homeless, children who are, or who have been in care.

    These groups often require special treatment or treatment in a special setting to accommodate their needs. The 2015/16 Oral Health Survey of Older People presented the results of a questionnaire and standardised dental examination of older people (aged 65 years and older) with mild dependency who live in "extra care" housing establishments. This is the first oral health survey of this population group and the method was implemented as a pilot. There is therefore no directly comparable data to use which could help to show trends.

64. Summary of vulnerable groups' oral health:

- 35% of those older vulnerable adults surveyed in Leicester reported having not visited a dentist in the last two years-similar to the national figure. Rutland was slightly higher at 37% and Leicestershire at 26%.

- A higher number of vulnerable adults require domiciliary dental care in Leicester than nationally (8% versus 5%)

- children with learning disabilities are more likely to have teeth extracted than filled and have poorer gum health

- adults with learning disabilities are more likely to have poorer oral health than the general population

- adults with learning disabilities living in the community are more likely to have poorer oral health than their counterparts living in care

- homeless people are more likely to have greater need for oral healthcare than the general population

65. The LLR Oral Health Oversight and Steering Group has had a particular focus on improving oral health and dental access for vulnerable adults including homeless persons and, more recently, been actively engaged with the inclusion oral health agenda with refugees and asylum seekers' oral health improvement and access in the city and beyond. Additionally, oral health and dental services are an integral part of the Enhancing Health in Care Homes agenda within LLR with a range of initiatives underway to improve oral health in care homes and for vulnerable older people in the community.

Background Papers *(excluding exempt items)*

66. *None*

Circulation under the Local Issues Alert Procedure

67. *None*

Officer to Contact

68. Tom Bailey (Senior Commissioning Manager, NHS England and Improvement – Midlands)
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List of Appendices

69. *N/A*

Equalities and Hunan Rights Implications *mandatory*

70. Acknowledgement of impact upon access to dental services for population of Leicestershire, particularly vulnerable patient groups, and the mitigating actions taken