ORAL HEALTH CARE IN RESIDENTIAL CARE HOMES
Evidence from Bolton and Kirklees

Healthwatch Bolton and Healthwatch Kirklees, February 2014

"Lost dentures. Toothache. Broken tooth. Simply need the routine oral health check up they are entitled to."
Kirklees Survey Respondent

"Oral care is recognised as a neglected area of practice''
"Promoting Older People's Oral Health, Practice Guidance", Royal College of Nursing,

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Introduction

In January 2014 Healthwatch Bolton published 'Accessing NHS Dentistry in Bolton'. The report highlighted a number of problems for patients trying to access NHS dentistry in Bolton including extremely low numbers of dentists accepting NHS patients at any given time. The research identified that those with difficulties accessing transport (as a condition of cost or physical access problems), those with additional needs (particularly wheelchair users and those with a variety of cognitive impairments such as autism and dementia) and the infirm and housebound experienced disproportionate problems in accessing dental services. [1]

Following the publication of "Accessing NHS Dentistry in Bolton' Healthwatch Bolton participated in a series of meetings (both locally and nationally) with oral health professionals. During the course of these discussions it became clear that;

- Local oral health professionals and Healthwatch activists shared a concern that the oral health needs of older people in Bolton were not being met.
- There is a significant clinical evidence base dealing with the oral health needs of older people.
- There is – in Bolton - sufficient infrastructure, experience and capability to research the issue in more detail ***and*** to elaborate feasible proposals to respond to the research findings.

As a result it was agreed that Healthwatch Bolton would proceed with this piece of research as a first step and springboard to the elaboration of practical proposals. The Local Dental Committee and the Oral Health Team have already signaled that they are willing to participate in the proposal making stage and Healthwatch Bolton are optimistic that senior staff in public health and at the Local Area Team will participate in such discussions.

In February 2014 Healthwatch Kirklees published 'Why Can't I find an NHS dentist in Kirklees?. The report highlighted a number of themes such as:

- Patients are routinely given misleading information about the availability of NHS dentists in Kirklees, leaving them confused and frustrated.
- Significant numbers of patients in Kirklees are struggling to find an NHS dentist for routine NHS treatment.
- Unequal access to NHS dentistry across Kirklees may be contributing to the wider issue of health inequalities.
- NHS dental contracts appear to be inflexible, based on historical demand and not an objective assessment of need, demand or accessibility. There is currently no NHS Dental Access Strategy for Kirklees.
- There were examples of poor practice which need to be raised with NHS England, the commissioner for NHS dentists.
- There is a developing issue specifically around dentures for older people, linked to the ageing population in Kirklees.

Following the publication of the report Healthwatch Kirklees met with Alison Knowles (Commissioning Director at NHS England in West Yorkshire) who was interested in the report, and will now use some of the information provided to feed in to the Dental Access Strategy that they are developing.

[1] 'Accessing NHS Dentistry in Bolton' Healthwatch Bolton, January 2014

Healthwatch Kirklees have also recently done a piece of work on patient's experience of using unplanned dental care clinics in West Yorkshire. This work was done in partnership with West Yorkshire Healthwatch and designed to feed into procurement of a new service that starts January 2015.

Following discussions between Healthwatch Bolton and Healthwatch Kirklees it was decided that the two organisations would run parallel surveys and publish the findings in a joint report. [2]

Background and Literature Review

Clinical Issues

More people are living longer and more of this group are living with some of their own teeth. General deterioration as well as numerous co-morbidities are widely reported including;

- General dental problems such as decay, gum disease, /collapsing teeth and tooth wear often become exacerbated by older age.
- The wearing of dentures, medication with high sugar content, certain medications and medication combinations (increasingly common among older people who may be living with multiple long term condition) can have serious implications for oral health including, dental caries, osteonecrosis, (a severe infection of the jaw bone), enlarged gums, dry mouth and oral thrush.
- The realities and assumptions of poor oral health can affect food choices and food preparation techniques and this can have a negative effect on nutritional status which in turn can contribute to other health problems including stroke and cardiovascular disease.
- Functional disability (such as might be caused by arthritis, stroke or Parkinson's disease), cognitive change (as caused by dementia) or motivational issues (as might be a symptom of mental ill health) can cause particular problems for older people with regards to maintaining oral hygiene.
- Royal College of Nursing guidance states that "it is estimated that 100 systemic diseases have oral manifestations (Haumschild and Haumschild 2009)." and a number of sources note links between oral health and diabetes mellitus, ischemic heart disease, chronic respiratory disease and aspirational pneumonia.[3]

Numbers of older people living in residential care

Nationally the data on numbers of people living in residential and nursing homes differs. The most reliable statistics are those drawn from the 2011 census which show 291,000[4] people aged 65 or over living in care homes in England and Wales.

Census data shows a relatively stable overall figure for the number of people living in care homes but it also identifies that this population group is ageing (59.2% of this group were aged 85 in 2011 compared to 56.5% in 2001).[5][6]

Locally the 2011 census gives the following figures for older members of the community (columns 2 and 3) and older people living in communal housing (columns 4 and 5) whilst local data shows 1545 residential care beds for older adults in Bolton and 2938 in Kirklees. Whilst not all of these places will be in use at

[2] Healthwatch Kirklees was chosen as a partner as Healthwatch Bolton and Healthwatch Kirklees are similar in terms of size and budget and serve similar communities. The two a Boroughs are similar in terms of size, demography and health status.

[3] "Promoting Older People's Oral Health, Practice Guidance", Royal College of Nursing, 2011, p7-10, "Dentistry in Care Homes", British Dental Association, 2012, "Oral Healthcare for Older People: 2020 Vision, A BDA Key Issue Policy Paper" BDA, May 2003

[4] This represents 3.2% of the total population at this age.

[5] 30.3% were aged 75 to 84 and 10.5% aged 65 to 74 in 2011. "Changes in the Older Resident Care Home Population between 2001 and 2011" ONS. August 2014, pp2-3

[6] Age UK report a 21% increase in people using ***local authority supported*** residential and nursing homes between 2005/6 and 2012/13 (increase in numbers from 135,000 to 164,000 people). "Care in Crisis 2014", Age UK, 2014

any one time, and whilst a small number are satisfied wit the dental care arrangements for their residents, these figures present a working number from which to plan an initial programme.

	Resident population	Resident population	Living in communal housing	Living in[7] communal housing	Residential care places available for older adults in Borough[8]	Number of residential care homes. for older adults
	65+	85+	65+	85+		
Bolton[9]	42,540[10]	5,328	1,035	572	1524	40
Kirklees	64,150	8,023	1,880	1,103	2938	76

It should be noted, however that with increasing numbers of older people living in their own homes consideration should also be given to extending any specialist services to, for example, older people using day centres.

Dentistry and Residential Care

There is little evidence based work on experiences of dental services among residents of care homes. The most commonly cited report on this subject is "Dentistry in Care Homes Research UK"[11] completed by the British Dental Association In 2012.

The basis of this research was a survey which included the views of 13 care home managers and 26 Clinical Director of salaried dental services from across the UK (England, Scotland and Wales).The survey explored daily oral hygiene, training of care staff, check ups, types of services used and contracting arrangements. The main findings of the report can be summarised as follows:

- Only half of the care homes reported that their residents receive regular check-ups.
- The care homes were evenly divided between those that used high street dentists, and those that used salaried primary dental care dentists.
- Residents of homes that used the services of salaried primary dental care dentists were much more likely to receive regularly scheduled check-ups and more likely to be able to access domiciliary visits than those services by General Dental Practices.
- Waiting times for appointments - both domiciliary and non domiciliary - were cited as being sometimes problematic.
- Resistance from residents was the most commonly cited problem with regards to daily oral hygiene and was often the only problem that managers reported.
- Many of the residents, and indeed some of the managers, believe that once a person has dentures they no longer need regular dental check-ups.
- Training for care staff about how to provide daily oral hygiene support was patchy.
- Information collected about the oral health of newly admitted care home residents varied hugely.
- Contracting, arrangement, monitoring measures and controls varied with a variety of different arrangements including "informal arrangements" in place.
- Problems were reported with demand for services outstripping the funding allocated,
- Services were considered to be poorly coordinated both locally (at Borough level) and nationally.

[7] **2011 Census Analysis, Changes in the Older Care Home Resident Population at Local Authority Level between 2001 and 2011 http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-382664**

[8] "Care Homes with nursing for adults contracted to Bolton Council", Bolton Metropolitan Borough Council, November 2014

[9] The most recent population projections from the Office for National Statistics predict substantial growth in the older population of Bolton. The over 65 population will grow from 44,700 at present to 61,400 by 2030 (an increase of 16,700).

[10] Population estimates for Bolton show that the number of over 65's had exceeded 45,000 by 2013.
"Older People JSNA, Who's at Risk and Why?" BMBC http://www.boltonshealthmatters.org/content/older-people-jsna

[11] "Dentistry in Care Homes", British Dental Association, 2012

Across the survey a programme of regularly scheduled domiciliary visits to all residents was the most common suggestion for improving the oral health of care home residents, whilst the Clinical Directors wanted to see formal contracting arrangements to ensure sufficient provision of services.

Policy into Action

In spite of the significant amounts of effort going into the development of integrated care models the focus remains firmly focussed on medical, nursing, re-ablement and social care. Surprisingly little attention has been paid either in the literature or within the commissioning process to dental services or, for that matter, to other primary care services such as optical care, hearing services, chiropody and so on. [12]

Both nationally and locally patients groups and oral health professionals continue to speak up for change. So far, however, little has been achieved to alleviate the situation. In 2003 the British Dental Association published "Oral Healthcare for Older People: 2020 Vision". The paper set out the following vision for oral healthcare services for older people:

In 2020, oral healthcare services for older people will need to be:

- recognised as an integral part of strategies to tackle inequalities in older people's health and to increase the quality of older people's lives;
- joined up and integrated at a local level with other health and social care services;
- accessible, of a high quality, available to all and patient centred;
- reflective of the diversity of the older persons population;
- in line with Government health policy (for example, helping enable older people to remain independent for longer);
- available equally to all older people on the basis of clinical need, regardless of age, geography or home circumstances.

By 2012, the BDA, unimpressed by the pace of change, published a second report, "Oral healthcare for Older People 2020 Vision, Check-up"[13] In which the authors noted that only 7 of the 23 recommendations of the original paper had been met. We have here selected 9 of the unmet or partially met recommendations that are underlined by the results of our own survey.

1. The new locally-commissioned system for the delivery of NHS primary care dentistry in England must take account of the needs of older people and the demographic and clinical changes identified in this paper.

2. Local health authorities must look creatively at dental provision for older people and tie in dentistry with other services, such as general medical practice, chiropody and pharmacy. Voluntary organisations and day centres are also means through which care can be brought to people (using mobile units).

3. Work on new NHS Clinical Pathways for dentistry must reflect the needs of the older persons population and ensure that further clinical challenges for dentists treating older patients in the future are not inadvertently created.

6. Marking of existing dentures for easy identification in residential homes should be available free to patients on the NHS.

7. Local health authorities should be encouraged to place simple contracts with local practices to provide care to a small number of residential care and nursing homes, with portable equipment for domiciliary work being made available on loan. Information about full and partial exemption from NHS dental charges should be simplified and publicised to older people and carers.

14. Planned reform of NHS dental charges should take account of the growth in the older persons population and the fact that older people are more likely to require more complex treatment and also tend to be among the least able to afford to pay. Free NHS examinations should be available to patients aged 65 and over across the UK.

15. The undergraduate dental curriculum should continue to include teaching of complete and partial dentures, and should also give students experience of domiciliary visits and care homes.

18. Community Dental Services should be resourced properly to enable CDS dentists to provide specialist services and clinical leadership to dentists and DCPs providing care for older people.

[13] "Oral healthcare for Older People 2020 Vision, Check-up" BDA January 2012

It is clear that, in dentistry at least, clinical leadership has less influence on commissioning than might be expected from the current NHS rhetoric.

It is also clear that - at least in Bolton and Kirklees - oral health professionals have not yet been able to find a route via which to adequately influence local health economies. Dental professionals have yet to come together to find a provider "envelope" (as GP Federations) and NHS England (which substantively manages primary care contracting) has not yet found a way to recognise or relate to the localisation agenda. The upshot is that oral health is is not adequately represented on local health and wellbeing boards (at least in Bolton and Kirklees).

Whilst some local Joint Strategic Needs Assessments (JSNAs) give some attention to Oral Health (including Bolton's but not Kirklees'), those that do tend to concentrate on children's oral health and / or addressing lifestyle factors that contribute to poor oral health (such as diet, smoking and alcohol reduction).[14] In line with this approach NHS England have, in recent years, tended to focus resources for special schemes and projects on additional services that benefit children. We at Healthwatch Bolton and Healthwatch Kirklees are left wondering if this is not "a tail wagging the dog situation".

That being said we are aware of a recent redoubling of efforts in this regard. The National Institute of Clinical Excellence (NICE) have recently (October 2014) published guideline PH55 "Oral health: approaches for local authorities and their partners to improve the oral health of their communities" [15]. The Guideline makes the following relevant recommendations (see Annex 1 for fuller extract).

Recommendation 1 Ensure oral health is a key health and wellbeing priority : Health and wellbeing boards and directors of public health should…Make oral health a core component of the joint strategic needs assessment and the health and wellbeing strategy. Review it as part of the yearly update.

Recommendation 8 Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health : Commissioners of health and social care services, including those that support people to live independently in their own home, should: Review all community health and social care service specifications to ensure oral health is included in care plans and is in line with safeguarding policies. Ensure service specifications include a requirement to promote and protect oral health in the context of overall health and wellbeing.

Recommendation 9 Commission training for health and social care staff working with children, young people and adults at high risk of poor oral health : Local authorities and health and wellbeing commissioning partners should: Commission regular, training for frontline health and social care staff working with groups at high risk of poor oral health.

In addition NICE have also been tasked by the Department of Health to "develop a public health guideline for carers working in health and social care settings (including nursing homes and residential care homes) on effective approaches to promoting oral health, preventing dental health problems and ensuring access to dental treatment when required."[16]

It is hoped that these new guidance documents will support our own efforts, and that of our colleagues, to ensure older people's oral health needs are properly considered and resourced within local health economies.

[14] "Why can't I find an NHS dentist in Kirklees? Healthwatch Kirklees, February 2014

[15] "Oral health: approaches for local authorities and their partners to improve the oral health of their communities" NICE guidelines [PH55] Published date: October 2014

[16] "Oral health in care homes draft scope for consultation 3 June –1 July 2014", NICE, June 2014

The Survey

Methodology

The focus of the joint Healthwatch Bolton – Healthwatch Kirklees survey was decided following discussions held in Bolton with representatives from the Local Dental Committee and the oral health team. These discussions identified domiciliary visits and oral heath promotion training as areas of concern, points confirmed by a a representative of BARCH. Following these discussions it was felt that there was a shared concern, considerable goodwill among the professionals concerned as well as skills and structures within the professional community that would be willing to contribute to seeking solutions.

It was decided that Healthwatch Bolton would make a survey of local care homes as a starting point. Healthwatch Bolton was keen to include other local Healthwatch in the project to ensure that the research was meaningful to commissioners and would make a useful contribution in the wider Healthwatch network. Healthwatch Bolton discussed the project with a number of other local Healthwatch and Healthwatch Kirklees agreed to participate.[17]

In planning this research a number of approaches were discussed. The need to gather information from across the Borough in order to get as complete a picture as possible was paramount and so it was decided that our best approach in this instance would be to speak to staff in residential homes and to use a short, relatively simple questionnaire of mainly factual questions.

A short questionnaire was elaborated. Healthwatch Bolton used a 10 question version and Healthwatch Kirklees a slightly extended 12 question version and a list of care homes was made for each Borough.

In Bolton two Healthwatch volunteers telephoned all the care Homes on the list. The call allowed us to introduce Healthwatch personally to Bolton Care home staff, to answer any wider questions on Healthwatch, to explain the background to the research and to go through the questionnaire, over the phone, ideally with the home manager. (November 2014). 43 homes were contacted 8 were difficult to get hold of and 5 only answered a few questions on the survey thus the Bolton sample size is 30 homes (70% of Bolton residential care homes.

Thus the total sample size is 65 residential care homes.

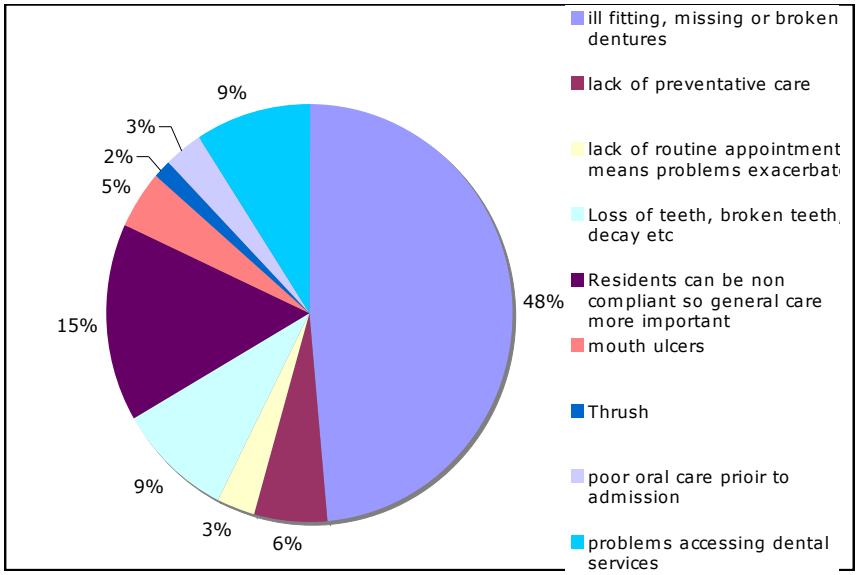
In Kirklees the questionnaire used by Healthwatch Bolton was elaborated and sent to all the care homes, along with a short email explaining who were are why we are the doing the survey. From the 76 care homes that were sent a survey 35 responded. Also, a Healthwatch volunteer telephoned all the care homes, to conduct the survey over the phone. The volunteered introduced Healthwatch, explained the aim and purpose of the survey and then went through the survey questions.

NEEDS

Managers were invited to comment freely on the question “What do you think are the main oral health issues for your residents? Some managers made more than one point and so results are reported as a % of the total comments.

[17] In this regard it is noted that BDA 2012 research surveyed only a small number (13) of care homes

What do you think are the main oral health issues for your residents?



Data from both Boroughs sample size 65

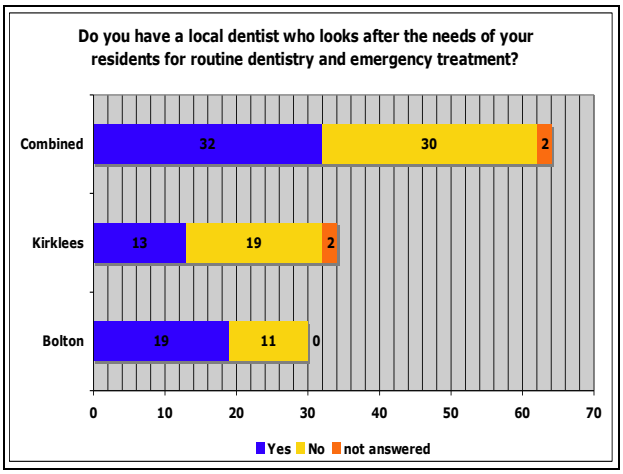
The most commonly cited problem was issues relating to broken, missing or ill-fitting dentures (48% of comments) followed by difficulties resulting from residents resisting oral health care interventions (15%). 9% of comments directly related problems accessing dental services, 9% mentioned broken teeth, tooth decay, loss of teeth and other common dental problems and 6% spoke about lack of preventative care with 3% stating that routine problems were exacerbated because of a lack of routine appointments. Other issues mentioned included mouth ulcers, oral thrush and poor oral care prior to admission.

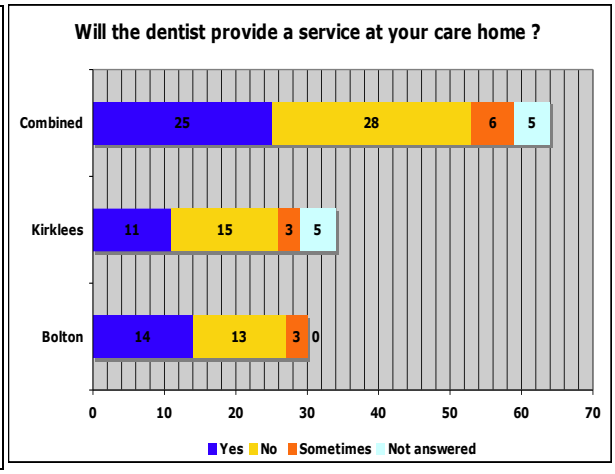
The responses list many of the problems described above but also comment on the impact of a lack of effective services (either before the resident arrived at the home or whilst the resident was living at the home). The sizable number who felt non-compliance to be the main problem may be indicative of a lack of training or support from oral hygiene specialists.

ACCESS TO SERVICES

The survey explored how care home managers worked with the dental system to secure access to treatment for their residents.

We asked if homes had a long term relationship with a dental service, asked for details of that service and asked if the dental services used would provide home visits.





Just under half of the homes surveyed (30) do not have a local dental service providing routine care to residents. This situation was worse in Kirklees were the number of homes without such a relationship was 19 (54%) compared to 11 (37%) in Bolton.

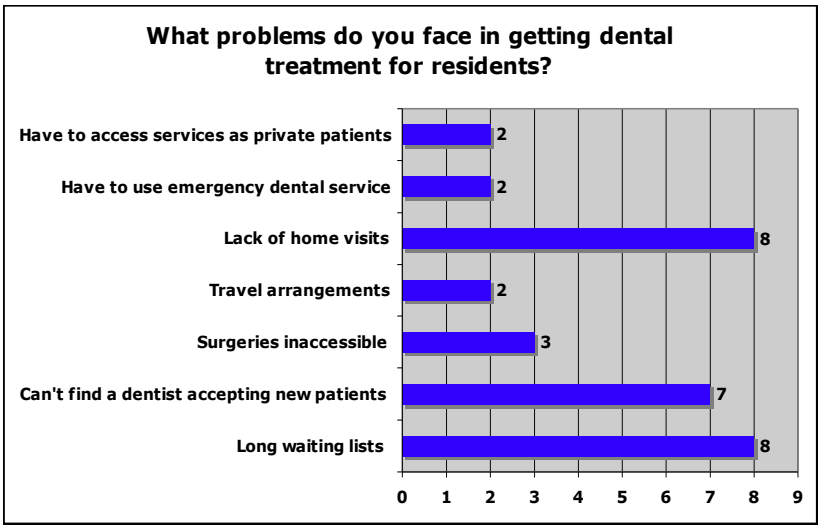
For Bolton of the 19 who answered yes to this question, ten named a local high street dentist, one named a dentist in a neighbouring Borough (though close to the home's location), six named the community/emergency dental service at Lever Chambers and two used Concepts Clinics a mobile dental service based in Yorkshire who specialise in working with older people.

For Kirkless, of the 13 who answered "Yes" four named a local high street practice and nine stated the local community/emergency dentist service which is provided by CIC Locala, although two of these stated that they were "waiting to have a service allocated".[18]

Across both sites those managers who reported no long term relationship with a dental service stated that they used residents former dentists, tried to register residents with a local high street dentist or used emergency dental services as required.

Homes in both Boroughs faced similar problems in accessing home visits. 26 (40%) stated that they were not able to access home visits and six (9%) stated that they were only able to do so sometimes. Thus

Kirklees asked "Have you experienced difficulties in getting the right dental treatment for any of your residents? E.g. long waiting lists for dentures, unable to get a dentist to come out and visit a resident." All 35 Kirklees respondents answered this question; long waits and lack of home visits were the most commonly cited problems (8 mentions each), followed by inability to find local dentists taking on new patients (7 mentions) and inability to find an accessible surgery (3 mentions) or difficulties making travel arrangements (2 mentions). Two managers stated that they relied on the emergency dental service and two stated that they had to use private dental services (at a premium cost to the residents).



[18] Either naming Locala directly or Cleckheaton Health Centre or The Princess Royal Dental Service -all of which are Locala run services.

Bolton

"The dentist will not give domiciliary service. This would be a massive help to dementia patients and infirm residents."

"Can't get residents registered as no places."

"Yes (we have been able to secure home visits) but only on rare occasions."

"A request is sent to Lever Chambers can take months too see residents."

Kirklees

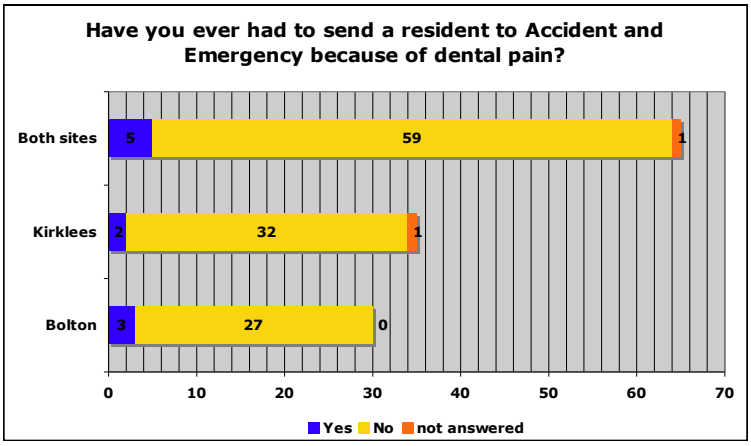
"Dentists are not willing to come to the home. If a resident does not have a dentist it is very hard, nearly impossible to access one locally."

"We are unable to find a dentist who will carry out a domiciliary visit. We have been unable to find a practice who is accepting NHS patients and who has a downstairs surgery with no steps into the building."

"The waiting lists for treatment are too long. Residents who need treatment often have to put up with ill-fitting dentures or painful oral conditions. There are not enough NHS dentists."

UNINTENDED CONSEQUENCES

We asked if anyone had had to send a resident to accident and emergency – clearly an undesirable outcome but especially so for an elderly person. Five homes across both sites (3 in Bolton and two in Kirklees reported that they had had to resort to this course of action.

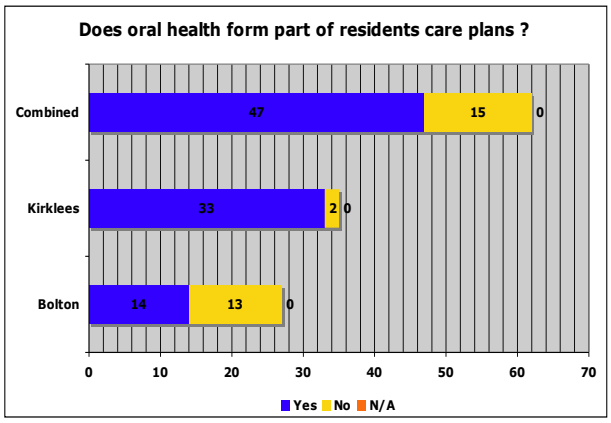


"a resident was in pain, we rang 101 to ask if they could help, they told us they could provide us with an emergency dentist. When we arrived at the dentists practice, it had no lifts and the resident was wheel chair bound. There was no lift access, they then told us to visit the GP but we couldn't get through. By the end of the night we had to take the resident to A&E at 8:00pm at night." (Kirklees Respondent)

PREVENTION

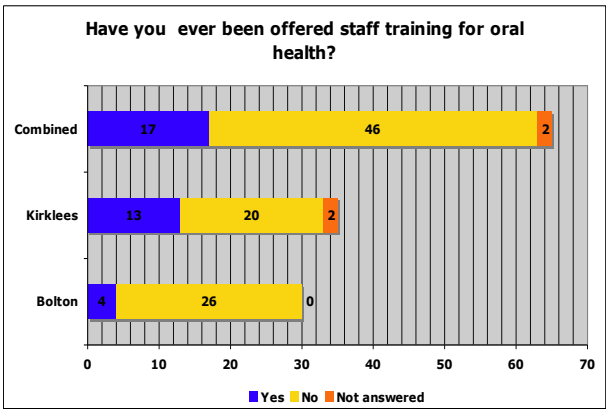
We asked two simple questions about oral health prevention. To try to understand how well oral health is prioritised and supported within the care homes. The first question asked if oral health formed part of the care plans of residents. In the majority of cases the home managers answered yes, but in a significant number (15/23%) the answer was no.

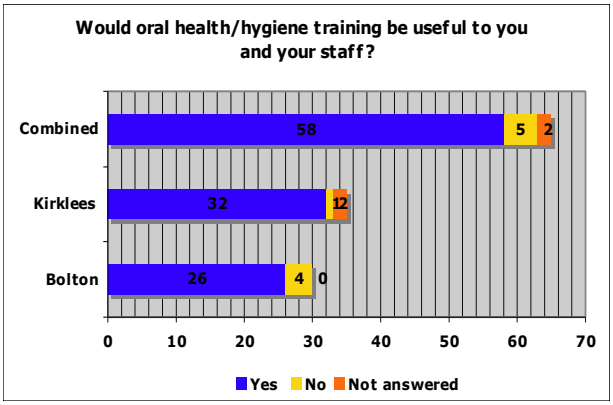
Bolton had significantly worse scores for this question with almost half of the homes (13/50%) stating that oral health did not form part of residents care plans.



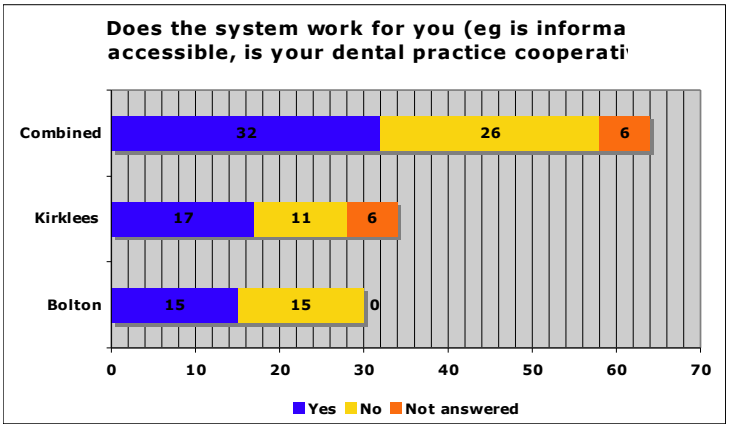
Only a quarter of the care homes (17 or 26%) surveyed had offered staff any training in oral health. The situation was much worse in Bolton where only four (13%) of the care homes had offered training of this kind. Of those that had, two had had this training from Bury Clinical Commissioning Group and one from Mencap.

When managers were asked if they thought oral health/hygiene training would be useful to their staff they answered with a resounding yes. 89% of care home managers said yes to this question, 91% of Kirklees respondents and 87% in Bolton.





DOES THE SYSTEM WORK FOR YOU?



Only half of the home managers stated that the dental system worked for them, 40% stated that the system did not work well for them and 10% declined to comment.

WHAT WOULD YOU LIKE TO SEE DONE DIFFERENTLY?

Most of the respondents would like to see a programme that provides home visits as a standard for care homes and their residents.

"A dentist service that visits at home, which is not a high street dentist - and support care homes.'

"More NHS dentists who are able to do home visits and routine dental care. A dentist that is dedicated to the needs of older people in care homes. It would be fantastic to have a mobile dentist who worked just with care homes." Dental practice

"More accessible, routine checks in the care home. Just like eye care, dental care should be prioritised. Its hard to get residents seen for an appointment at the dentist."

"Domiciliary services should be mandatory for older people living in care homes. It is a vital and essential service. I would like to see that older people matter, that their needs are seen as important. Dental services are failing older people by refusing to provide a domiciliary service or at least ensure their buildings/surgeries are accessible. I would like to see this changed."

"For dentists to visit the home. For care home residents to be allocated a named dental practice if they do not already have one.

"If living in a care home all visits should be home visits, all over 75's should be free as a lot can't afford to pay"

"A visiting dentist for regular check ups and treatment"

"Dentist visits for check up regularly."

Some respondents made suggestions that focused on adapting general dental practice to make it more accessible and appropriate for the needs of older people.

"We would like to see shorter waiting lists. Perhaps the dental practice could prioritise rather than put someone at the end of a waiting list.

"More time to be given to care homes through the National Health Service as time for visits is very limited. The Dentists are running a busy practice, and appointment times are very limited"

"To ring a direct number to get through to them. A service just for the elderly as they get forgotten about."

" More training for staff." "Dentist to have training in dementia."

"Could initials be put on dentures?"

Perhaps the most poignant comments, however are those that simply ask for care home residents to be able to access the basic service NHS service to which they are entitled.

"Access to a service."

"I would just like to find a dental practice that accepts NHS patients"

"Simply need the routine oral health check up they are entitled to."

CONCLUSIONS

Our research has shown that people living in residential care (and the people looking after them) face serious difficulties in accessing appropriate services that will support their oral health, prevent oral health problems or respond to oral health problems when they arise.

Current services are not responsive to the need of this population group. Current service design places unrealistic expectations on both residents and their carers with regards to a) waiting times for appointments b) expectations to attend regular appointments c) assumptions about how oral health and hygiene is approached.

46% of the care homes surveyed lack a sustained relationship with a dental service provider and 40% are unable to secure home visits. These facts surely contribute to a 50% dissatisfaction rate with the dental care system and show that there is much work to be done to ensure safe, effective, equitable and dignified access to oral health services for the residents of care homes in Bolton and Kirklees.

23% of all the care homes surveyed and 50% of those surveyed in Bolton do not include oral health in residents care plans. Only 26% of the care homes surveyed had offered oral health training to staff across the two sites, in Bolton this figure was just 13%. On the positive side an overwhelming 89% of managers surveyed said that they would welcome such training.

The lack of attention to the oral health of people in care homes has a number of unintended consequences the most extreme of which might be recourse to accident and emergency departments as a direct consequence of lack of access to primary services. In this respect 5 of the 65 homes surveyed stated that they had had to resort to sending a resident to A & E as a result of not being able to access appropriate dental services.

It should not be noted that oral health problems interact with people's wider health problems. Older people need specialised preventative services that are designed to work with this reality and clinical services that recognise the particular problems older people might face in accessing standard dental appointments.

The policy environment increasingly recognises the need for an holistic and integrated approach to health, and researchers show both a clear impact of long term health conditions on oral health and to demonstrate how improved oral health can contribute to improved health and wellbeing outcomes among older people.

There is a need for all health economy players to act on this evidence and to develop viable and sustainable approaches to commissioning and delivering appropriate oral health services for older people.

NHS bureaucrats may well argue that there has been a shift in thinking on the subject of older people's oral health care and it may be true that new opportunities have been opened up by this shift. However, our survey results show that for our older community members and care home residents, the situation on the ground is no where near achieving the British Dental Associations' 2020 vision.

RECOMMENDATIONS

Nationally

1. NHS England needs to engage with the care sector to a) clarify expectations and responsibilities regarding the management of oral health and dental care for people living in residential care b) establish guidelines and resources that address the training and information gap among care professionals.

Local and Regional Level

2. LATs need to sufficiently resource local dental professionals (either high street or specialist or a mixture of both) to provide an appropriate amount of domiciliary care and sort out the contracting so as to clarify – and recompense – expectations and responsibilities for domiciliary dental visits. The ideal scenario for care home residents would appear to be is a programme of regular dental check ups offered in their home. Such a programme might offer a full programme of care (a fully mobile service) or might offer check ups, minor interventions and denture care services with residents being referred to a specialist provider for more complex work.

3. Expectations (and legal obligations) regarding accessible premises need to be taken into account when establishing and monitoring NHS dental contracts.

4. LATs need to arrange appropriate representation at local level via local Health and Wellbeing Boards and (where they exist) Integrated Care Boards.

5. LATs should contribute to pooled integrated care budgets and co-commission, alongside integrated care teams and public health bodies, oral health services that reflect local conditions and dovetail with local integrated care plans.

Local level

6. Health and Wellbeing Boards should ensure that oral health is on local agenda and follow the NICE (P55) guidance by establishing of a group of relevant professionals and developing a local needs assessments for older people's oral health.

7. Joint Strategic Needs Assessments should create a chapter on oral health (where there is not one) and ensure older people's oral health needs are reflected therin.

8. Public Health / LAT should commission the oral health team to deliver a training programme in oral health to care providers, in line with the RCN Guidance.

9. Commissioners need to ensure that clear, accessible Information on oral health care arrangement and entitlements if made available to residents, carers and managers of care homes.

10. All care home managers need to put oral health into the care plans and provide oral health training for staff and this should become part of the LA contract when funding care home places. (This is particularly relevant in Bolton).

11. Local Commissioners should give serious consideration to utilizing the oral health teams to provide a programme of activity similar to that provided in schools (oral health checks, oral health promotion, fluoride paste intervention) tailored towards the needs of older people and delivered both in residential care settings and older people's day centres. Such a programme would provide a first line preventative service and make an important contribution to a base line assessment on the state of older people's oral health locally.

12. Healthwatch Bolton and Healthwatch Kirklees are willing, in the first instance, to convene the sub group named in recommendation 1 of NICE Guidance [PH55].

13. Local Dental Committees should come up with a solution for putting initials on dentures.

14. Healthwatch Bolton and Healthwatch Kirklees will do a follow up report within the next 18 months to see if the situation had improved.

ACKNOWLEDGEMENTS

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REFERENCES

"Accessing NHS Dentistry in Bolton" Healthwatch Bolton, January 2014

"Adult Dental Health Survey, CH 8: Access and barriers to care", The Health and Social Care Information Centre, 2009

"Dentistry in Care Homes", British Dental Association, 2012

"Kirklees JSNA", Kirklees Council, http://www.kirklees.gov.uk/you-kmc/partners/other/jsna.aspx

"Why can't I find an NHS dentist in Kirklees? Healthwatch Kirklees, February 2014

"Older People JSNA, Whos at Risk and Why?" Bolton Metropolitan Borough Council http://www.boltonshealthmatters.org/content/older-people-jsna

"Older People and Housing JSNA" Bolton Metropolitan Borough Council http://www.boltonshealthmatters.org/content/older-people-and-housing-jsna

"Oral health: approaches for local authorities and their partners to improve the oral health of their communities NICE guidelines [PH55]", NICE, October 2014

"Oral Healthcare for Older People: 2020 Vision, A BDA Key Issue Policy Paper" BDA, May 2003

"Oral healthcare for Older People 2020 Vision, Check-up" BDA January 2012

"Oral health in care homes draft scope for consultation 3 June –1 July 2014", NICE, June 2014

"Promoting Older People's Oral Health, Practice Guidance", Royal College of Nursing, 2011

"Safe, compassionate care for frail older people using an integrated care pathway:
Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders," NHS England, Feb 2014

"Standard General Dental Services Contract", NHS England, Last revised April 2013

"2011 Census Analysis, Changes in the Older Care Home Resident Population at Local Authority Level between 2001 and 2011" http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-382664

ANNEX 1 Current System of Dentistry Provision

As with GPs, local dental practices are private organisations. Dental Surgeons and their colleagues (Dental practitioners, Dental Technicians and Dental Hygienists) are registered with the relevant professional bodies and are obliged to cooperate with the healthcare regulation system (CQC etc). Dental practices are under no obligation to work with the NHS and the standard business model is a mixed one where practices have private patients and an NHS contract running in parallel. Beyond the confines of professional regulation and (in the case of NHS work) contract compliance, dental practices are free to operate as they wish.

Dental Surgeries therefore have no specific obligation to serve their local population (though this clearly makes business sense), no obligation to work with vulnerable adults and no obligation to make home visits, they can, if they wish, hold waiting lists and choose which patients they treat.

Those dentists who do work on behalf of the NHS do so via a system of contracts with NHS England, these are managed at a local level by Local Area Teams (LATs).[19]

Within the standard NHS contract Mandatory obligations are as follows:

PART 8: MANDATORY SERVICES

Mandatory services

73. Subject to clause 74A, the Contractor must provide to its patients, during the period specified in clause (…) , all proper and necessary dental care and treatment which includes—

74.1. the care which a dental practitioner usually undertakes for a patient and which the patient is willing to undergo;

74.2 treatment, including *urgent treatment*; and

74.3 where appropriate, the referral of the patient for *advanced mandatory services*, *domiciliary services*, *sedation services* or other relevant services provided under Part [5] of *the 2006 Act*.

20

In the "Standard General Dental Services Contract" domiciliary services are covered in **Part 9 Additional services**; Advanced mandatory services (p51) this section of the contract (Additional Services) is bounded by the following clause:

"PART 9; ADDITIONAL SERVICES; Advanced mandatory services

(101) The Contractor may only provide *advanced mandatory services* under the Contract as a *referral service*."

21

The specialist contracting is, by and large, vested in "Community Dental Services" contracts. In Bolton this contract is with Bridgewater Community Healthcare NHS Foundation Trust[22] and in KIrklees this is with Locala, a Community Interest Company.

[19] This is the contracting system for all NHS Primary Care contracts, including General practitioners, opticians, pharmacies, chiropodists, etc).
[20] "STANDARD GENERAL DENTAL SERVICES CONTRACT", NHS England, Last revised April 2013, p43
[21] "STANDARD GENERAL DENTAL SERVICES CONTRACT", NHS England, Last revised April 2013, p51

As with other aspects of the Standard Dental Contract, specialist dental care is allocated and paid for either in UDA's (Units of Dental Activity).Each contract specifies the number of UDAs allocated to the contractor. It is the Local Area Team of NHS England that decides the allocations of UDA's in each area and which manages the contracts.

In addition Commissioners do commission special projects aimed at addressing the needs of specific population groups for example;

- Baby Teeth Do Matter, a pilot initiative aimed at increasing attendance of under 5s. (NHS England)
- Brushing for Life, a health visitor led programme designed to promote regular brushing of young children's teeth using toothpaste with no less than 1,000 ppm of fluoride content. Health visitors provide oral health advice and support for parents and babies at the eight month assessment, along with giving them a toothbrush, toothpaste and information leaflet. (LA Public Health)
- The Dental Access Voucher Scheme, which aims to ensure that vulnerable children, including looked after children and children on a safe guarding plan are able to access care with a local dentist quickly and efficiently. (LA Public Health)
- Prison Dental Services, which aims to improve the quality and reduce the cost of dental care in prisons (NHS England)

ANNEX 2

"Oral health: approaches for local authorities and their partners to improve the oral health of their communities" NICE guidelines [PH55] Published date: October 2014. Expanded Extract.

Recommendation 1 Ensure oral health is a key health and wellbeing priority

Health and wellbeing boards and directors of public health should:

- Make oral health a core component of the joint strategic needs assessment and the health and wellbeing strategy. Review it as part of the yearly update.
- Set up a group that has responsibility for an oral health needs assessment and strategy. Ensure the following contribute to the work of the group:
    - a consultant in dental public health
    - a local authority public health representative
    - an NHS England commissioner of local dental services
    - a representative from a local professional dental network
    - a representative from the local dental committee
    - representatives from children and adult social care services
    - a local Healthwatch representative
    - a senior local government representative to lead on, and act as an advocate for, oral health
    - representatives from relevant community groups.

Recommendation 8 Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health

[22] As part of a Local Dental Network which covers Ashton, Leigh & Wigan, Bolton, Halton & St. Helens, Stockport, Tameside & Glossop, Trafford, Warrington and Western Cheshire.

Commissioners of health and social care services, including those that support people to live independently in their own home, should:

- Review all community health and social care service specifications to ensure oral health is included in care plans and is in line with safeguarding policies.
- Ensure service specifications include a requirement to promote and protect oral health in the context of overall health and wellbeing. Relevant services include substance misuse services and those supporting people living independently in the community. (For example, people who are homeless or living in hostels, those who experience physical or mobility problems, people with learning difficulties, and people experiencing mental health problems.)
- Ensure service specifications include:
    - an assessment of oral health, including a referral, or advice to go to a dentist or other clinical services (this may be because of pain, concerns about appearance or difficulty in eating)
    - making oral health care, including regular dental check-ups, an integral part of care planning – through self-care or clinical services
    - support to help people maintain good oral hygiene (including advice about diet)
    - staff training in how to promote oral health – during inductions and then updated on a regular basis (see recommendations 7 and 9).

Recommendation 9 Commission training for health and social care staff working with children, young people and adults at high risk of poor oral health

Local authorities and health and wellbeing commissioning partners should:

- Commission regular, training for frontline health and social care staff working with groups at high risk of poor oral health. This should be based on 'advice for patients' in Delivering better oral health. The aim is to ensure they can meet the needs of adults, children and young people in groups at high risk of poor oral health. The training should include:
    - Basic assessment and care planning to promote and protect oral health.
    - How good oral health contributes to people's overall health and wellbeing.
    - The consequences of poor oral health, for example, dental pain and infection. (This can exacerbate symptoms associated with dementia and can also contribute to malnutrition among older people.)
    - How the appearance of teeth contributes to self-esteem.
    - Causes, symptoms and how to prevent tooth decay (including root caries in older people), gum disease and oral cancer, for example:
        - the role of plaque in gum disease and how it can affect the immunity of people with diabetes
        - the role of high-sugar diets
        - the link between the use of sugar-sweetened methadone and poor oral health
        - smoking and other tobacco products as a risk factor for oral diseases such as gum disease and oral cancer (see the NICE guideline on smokeless tobacco cessation).
    - Techniques for helping people maintain good oral hygiene (including the use of fluoride toothpaste).
    - Local pathways for accessing routine, urgent and home care and specialist services.
    - How to encourage and support people to register with a dentist and how to act as an advocate to ensure others can use services.
    - Entitlements to free dental treatment or help with costs.
    - Information on local voluntary sector organisations that may be able to offer additional advice, help or advocacy services.
    - What advice to give to carers.

ANNEX 3

Meeting to consider the draft report, Healthwatch Bolton Offices 27 February 2015

Summary of Discussion and suggestions in relation to the Report's Recommendations

In attendance: Alice Tligui, Leah Elcock, Jim Fawcett (Healthwatch Bolton), Shabana Ali (Healthwatch Kirklees), Lindsey Bowes (NHS England LAT), Jean Holgate (Oral Health Team), Marie Wilson (Bridgewater), Robin Heywood and Mark Ray (Local Dental Committee).

The purpose of this meeting was to seek responses to the report and look for practical steps forward that a) would address some of the issues raised and b) could be initiated from within this group.
The meeting discussed a number of aspects of the report and raised a number of further questions as follows:

- The meeting noted the absence of someone in a position to speak for the care sector.
- On the question of whether this is a local or a national issue. It is certainly an issue in Kirklees and Bolton, Healthwatch will circulate the final report to the whole Healthwatch Network to establish if this is a national issue. From the DNA 2013 research it would seem it is a wider issue.
- The meeting recognises that though the report looks at older people living in care homes, there is a much larger population of older people, some of whom have the same issues, who receive care in the home. There may well be a case to examine the dental needs of this group in more detail in future but it is felt that concentrating, for the time being, on tackling the needs of the relatively small and stable number of people living in residential care homes is a more realistic goal.
- Among care home residents there are a number of different circumstances that apply, some people may be willing and able to attend regular dental appointments in community settings, others may not be physically able to do this and yet other may find this a very distressing experience. This research is basically concerned with access to services and not with clinical detail. There is other work going on within the Local Area Team which might feed a more comprehensive needs assessment of the older population in terms of epidemiological /clinical needs data.
- The meeting discussed the questions of clarity of responsibility in terms of domicile ary visits. It appears that some dentists do home visits for some of their current patients and the community dental service has some capacity to do home visits however it became clear at the meeting that the actual situation was not well known or understood by all the relevant service providers and that therefore coordination of home visits requests was non-existent.
- The meeting also discussed whose responsibility it was to ensure care home residents had appropriate access, was it the care provider, the resident or their representatives or the dental community? It appears that this point is also unclear and has again led to a situation of poor communication, information and coordination.
- There was some discussion about the need to work with specialist and experienced providers as all work with frail elderly patients presents challenges and risks, particularly where the people concerned are bed bound or have cognitive impairments such as those associated with dementia, for example. Some discussion was also had on the issues associated with CQC registration in the context of home visits.

- The relative merits of domiciliary visits were discussed and the meeting agreed that a mixed approach involving oral hygiene, appointments in the community with dentists with accessible premises and domiciliary visits probably represented the best most appropriate and cost effective solution.
- The assembled professionals looked to the algorythmn already in use for providing oral health services to Looked After Children as a useful starting point for building a sensible and effective service.

Recommendations and Actions

The meeting considered each of the Report's recommendations in turn and suggested the following actions:

Nationally

Recommendation 1:
NHS England needs to engage with the care sector to a) clarify expectations and responsibilities regarding the management of oral health and dental care for people living in residential care b) establish guidelines and resources that address the training and information gap among care professionals.

Actions:
1a) Healthwatch Bolton and Healthwatch Kirklees will escalate this issue via Healthwatch England (HWB and HWK)
1b) In addition it was agreed that HWB and HWK should share the report with the Lead Inspector for dental services at the CQC in order to seek clarifications on the issue of CQC registration of providers in this context.

Local and Regional Level

Recommendation 2 :
LATs need to sufficiently resource local dental professionals (either high street or specialist or a mixture of both) to provide an appropriate amount of domiciliary care and sort out the contracting so as to clarify – and recompense – expectations and responsibilities for domiciliary dental visits. The ideal scenario for care home residents would appear to be a programme of regular dental check ups offered in their home. Such a programme might offer a full programme of care (a fully mobile service) or might offer check ups, minor interventions and denture care services with residents being referred to a specialist provider for more complex work.
The meeting offered an adapted vision here ie a coordinated programme combing; a) oral hygiene interventions in all care homes to include promotion, prevention and education work b) two options for dental surgery interventions; community based appointments with an approved list of community dentists (those eligible to be part of the scheme should have appropriate expertise and accessible premises) and an appropriate number of domiciliary vists made available contracted either with Community Dental Services of community dentists or a combination of these.

Actions:
2a) Oral Health Team offered to proffer an outline costing of such a service based on experience of the voucher scheme currently in use with Looked After Children in Bolton. (This document received and appended below "Sketch Costing")
2b) Healthwatch Bolton to raise this suggestion with LA Public Health Lead.

2c) Local Dental Committee will discuss with members and put forward a list of appropriate and interested Practices.
2d) Greater Manchester Dental Clinical Directors Meeting will discuss if this work can be considered as a pilot programme within an initiative they are already discussing.
2e) LAT to provide details of the current contract situation with regards to domiciliary visits in Bolton – how many are contracted and with whom? How many are 'spent' and with whom?

Recommendation 3
Expectations (and legal obligations) regarding accessible premises need to be taken into account when establishing and monitoring NHS dental contracts.
This issue dealt with within the proposals being put forward by the use of an approved list of local dentists.

Action
3a) Healthwatch Bolton and Kirklees may consider how to take this issue forward within the wider HW remit.

Recommendation 4:
LATs need to arrange appropriate representation at local level via local Health and Wellbeing Boards and (where they exist) Integrated Care Boards.

Actions
4a) This action needs to be pursued by the HWB Boards in Bolton and Kirklees.
4b) Service Providers (LDC and CDS) would like to feel included in the HWBB Process and be kept informed of discussions concerning oral health, whether this be by invitation to relevant meetings or by other means. HWB Boards to consider and respond to this point.
4c) An all round effort needs to be made by strategic leaders to ensure that discussions on primary care include all primary care players and not only those concerned with medical issues.

Recommendation 5
LATs should contribute to pooled integrated care budgets and co-commission, alongside integrated care teams and public health bodies, oral health services that reflect local conditions and dovetail with local integrated care plans.

Actions
5a) as 4c) An all round effort needs to be made by strategic leaders to ensure that discussions on primary care include all primary care players and not only those concerned with medical issues.
5b) Strategic Leaders need to redouble efforts to coordinate efforts with NHS England in order that the skills and capabilities of all system players can be harnessed, coordinated and optimized.

Local level

Recommendation 6
Health and Wellbeing Boards should ensure that oral health is on local agenda and follow the NICE (P55) guidance by establishing of a group of relevant professionals and developing a local needs assessments for older people's oral health.

Action
6a) HWB Boards need to affirm this course of action. Healthwatch Bolton and Healthwatch Kirklees have offered to lead on the convening of these groups.

Recommendation 7

Joint Strategic Needs Assessments should create a chapter on oral health (where there is not one) and ensure older people's oral health needs are reflected therin.

Actions
7a) Kirklees HWB Board should review their stance in this regard.
7b) Bolton HWB Board should review its current chapter to ensure that it considers the needs of older people effectively.

Recommendation 8
Public Health / LAT should commission the oral health team to deliver a training programme in oral health to care providers, in line with the RCN Guidance.

Actions
8a) as 2a) Oral Health Team offered to proffer an outline costing of such a service based on experience of the voucher scheme currently in use with Looked After Children in Bolton. (This document received and appended below "Sketch Costing")
8b) as 2b) Healthwatch Bolton to raise this suggestion with LA Public Health Lead.

Recommendation 9
Commissioners need to ensure that clear, accessible Information on oral health care arrangement and entitlements if made available to residents, carers and managers of care homes.

Action
9a) HWB and HWK will raise this issue with commissioning and quality leads within the care home sector and seek next steps from these conversations.

Recommendation 10
All care home managers need to put oral health into the care plans and provide oral health training for staff and this should become part of the LA contract when funding care home places. (This is particularly relevant in Bolton).

Action
10a) as 9a) HWB and HWK will raise this issue with commissioning and quality leads within the care home sector and seek next steps from these conversations.

Recommendation 11
Local Commissioners should give serious consideration to utilizing the oral health teams to provide a programme of activity similar to that provided in schools (oral health checks, oral health promotion, fluoride paste intervention) tailored towards the needs of older people and delivered both in residential care settings and older people's day centres. Such a programme would provide a first line preventative service and make an important contribution to a base line assessment on the state of older people's oral health locally.

Actions
11a) as 8a) and 2a) Oral Health Team offered to proffer an outline costing of such a service based on experience of the voucher scheme currently in use with Looked After Children in Bolton. (This document received and appended below "Sketch Costing")
11b as 8b) and 2b) Healthwatch Bolton to raise this suggestion with LA Public Health Lead.

Recommendation 12
Healthwatch Bolton and Healthwatch Kirklees are willing, in the first instance, to convene the sub group named in recommendation 1 of NICE Guidance [PH55].

Action:
12a) as 6a) HWB Boards need to affirm this course of action. Healthwatch Bolton and Healthwatch Kirklees have offered to lead on the convening of these groups.

Recommendation 13
Local Dental Committees should come up with a solution for putting initials on dentures.

Action
13a) LDC will lobby its members to make this request as standard when dentures are being made.

Recommendation 14
Healthwatch Bolton and Healthwatch Kirklees will do a follow up report within the next 18 months to see if the situation had improved.

14a) HWB and HWK to reconvene during summer 2015 to discuss progress to date and approaches to a follow-up report.

<u>Sketch costing from Bolton Oral Health Improvement Team</u>

Looking at the results from your report and the detailed discussion we had around the table it is evident to see that the Oral Health Improvement Team are pivotal in providing preventative training for staff working within care homes, along with support for residents and a key link professional that can co-ordinate between the care homes and the relevant dental practices.
"It is a well recognised that oral health has an important role in the general health and well –being of individuals and it is of concern that significant inequalities in oral health exist across England" (*Dept of Health – Delivering better oral health an evidence-based toolkit for prevention 3rd edition September 2014).*
From your data the total sample size of care homes in Bolton is 65 with a resident population 65+ of 1,035 and 85+ of 572, a large number of these patients will have their own dentition.
A very quick costing for implementing a preventative care package for all the 65 care homes across Bolton would involve:

- 0.5WTE Oral Health Improvement Officer = £ 19,000
- 1.5WTE Oral Health Improvement Educators = £ 50,222
- Travel Costs = £ 1,000
- Resources/ Equipment = £ 3,000
- Total = £ 73, 222

As you can see this is a small amount in the scheme of things to ensure that our aging population can benefit from a good oral health which is pain free and comfortable.

- Jean Holgate,
- Oral Health Improvement Manager, Oral Health Improvement Dept, Bolton