Special Care and Paediatric Dentistry South East Needs assessment summary report

September 2019

NHS England and NHS Improvement

Contents

I went to the same dentist for 10 years, but I was never asked what the experience was like for me. [public voice]

What surprises me is that this dentist has been available to me for at least five years, and I didn't know existed. [public voice]

1. Introduction

1.1. Purpose

1. To give an overview of 'where are we now' in relation to special care and paediatric dentistry in relation to:
   - Existing service provision (what is provided, where, for home, how much, at what cost)
   - Population need, including the public view

2. Describe the findings in a way which supports commissioners to:
   a. Improve patient pathway (vertically and horizontally)
   b. Remove gaps in service provision
   c. Improve quality of service (e.g. more closely align design to what potential users want)
   d. Reduce inequalities in access to care
   e. Integrate special care and paediatric dental services into the wider health and social care system

1.2. Assessing need is a process

Assessing need for the purposes of commissioning is a process. This document summarises the process followed in this needs assessment, and the various outputs that have followed.

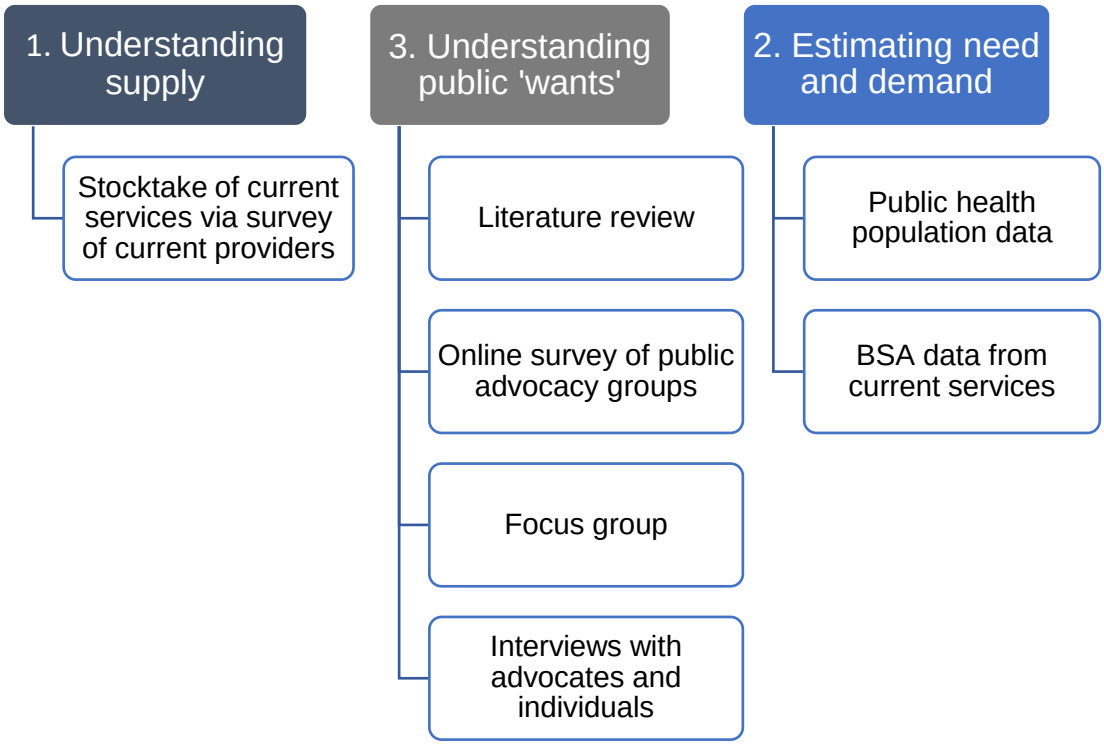
Taken together these outputs will directly support the commissioning of special care and paediatric dentistry by informing the service specification, lot development and the funding formula. Findings of this (and any) needs assessment will need to be worked up into commissioning decisions through a further process, e.g. working with stakeholders to refine what the service should deliver, what would locations would be practical, how to define service lots.

This needs assessment has:

- Gathered and analysed relevant data
- Identified issues with patient pathway
- Identified gaps in service provision
- Reported the public view

Needs assessments are not uniform in nature: they vary in many ways, including the purpose of the work and the data that is available to analyse.

1.3. Components of this needs assessment



1.4. What methods were used and why they were chosen

Method	Justification
Survey of current providers	• Variation in knowledge across SE about what currently being provided • Survey developed with MCNs
Analysis of existing public health data to estimate normative needs	• Pragmatic solution, not possible to gather primary data for multiple population groups
Analysis of BSA activity data to estimate demand	• Unable to use waiting times and number of referrals as data not comparable between services • Data reliable and accessible
Literature review	• Needed to understand existing knowledge on these groups • Didn't want to duplicate collection of existing data
Online survey of representative groups	• Recommended by Health and Wellbeing Alliance members as best method to engage (learned via Webinar discussion)
Focus group	• To add depth to themes learned from literature review and online survey • Limited existing data
Interviews with advocates and individuals	• Opportunistic learning from people unable to engage trough other methods. Vital to understand preferences of people with severe LDs who cannot communicate their own needs.

Further detail on methods used is given in the relevant sections below.

1.5. A pragmatic approach to assessing need for Special Care and Paediatric dentistry

Type of need	Issue	Pragmatic solution
Normative need for paeds/special care	• Not everyone with additional needs will require special care/paeds • There is no way to predict what type of treatment, or how much treatment, an individual, or group of individuals, will need. • No direct relationship between clinical need and what or how much treatment they will have. Can't quantify • Felt need for paeds/special care	• Focused on data that are routinely collected for core groups • Made assumption that everyone classified in these groups will have need for dental care
Perceived needs	• Data not routinely collected on felt oral health needs of target groups • Difficulty in collecting data directly from people who may have communication/consent issues	• Gathered primary qualitative data (not designed to be representative) • Questions focused on what people want from services and how to improve access to care
Expressed need or demand for paeds/special **care**	• Usually measured by looking at waiting times and referrals • Data collected by services in multiple ways so not able to collate and compare at a population level	• Quantitative data: gathered routinely collected activity data from current CDSs via BSA • Qualitative data: through public engagement work

1.6. Outputs of the needs assessment

This summary document forms the final output of the needs assessment.

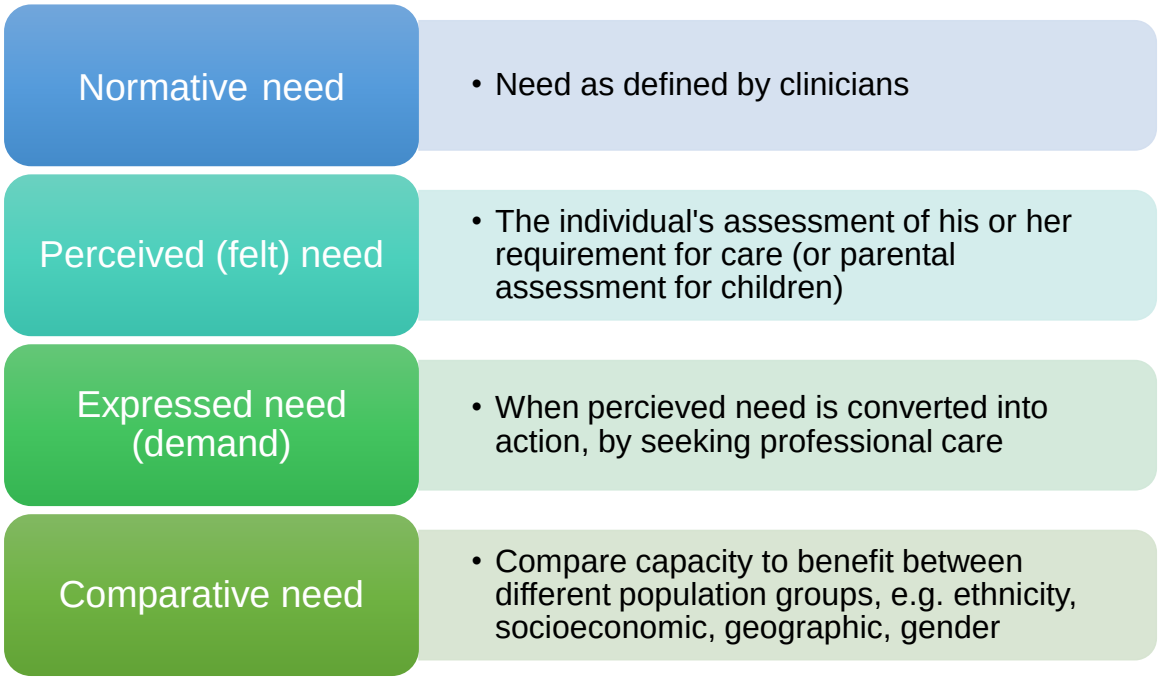
The 4 stages, and associated outputs, are summarised below.

Stage	Outputs
1. Understanding supply	• Slide set on findings of stocktake
2. Estimating level of need and demand in the population	• South East data spreadsheets
3. Understanding what the public wants	• Slide set on findings of literature review and survey • Slide set on findings of focus group and interviews • Summary slide set
4. Summary of methods and findings	• This report

2. Types of need

Need for health care is often defined as a 'capacity to benefit', in this case from special care or paediatric dental care. There are several types of need (figure below). While this may seem unduly complicated, it reflects the unpredictable and subjective nature of need.

Figure: Types of need



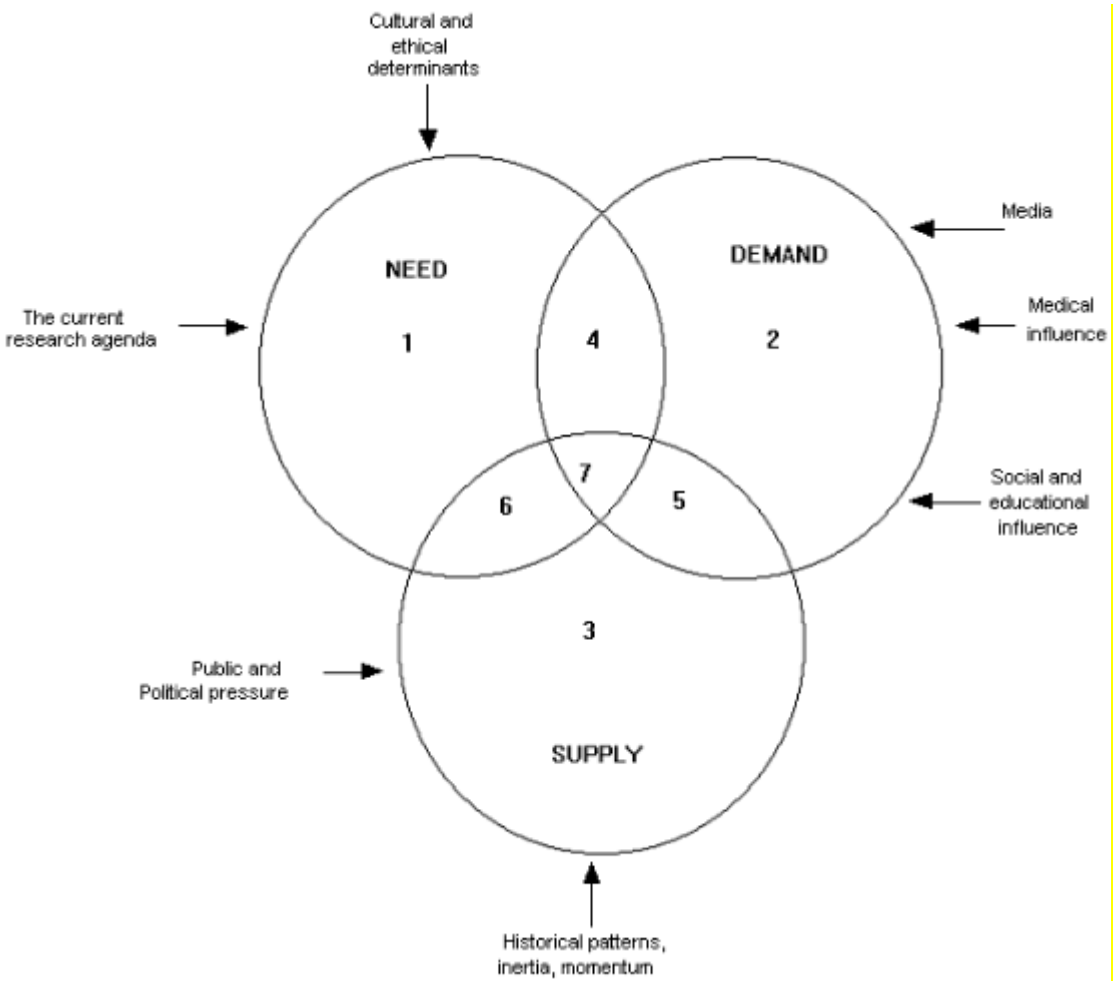
As such it can be challenging to quantify what individuals or population groups have capacity to benefit from treatment and which does not

It is important to consider comparative need: in a context of increasing need and limited resources it is relevant to look at the added value of different interventions, e.g. what population needs will be met by spending on special care dentistry in a clinic versus spending on domiciliary care. It is also crucial to look at inequalities in need and attempt to address those through any resulting action plan or strategy, e.g. inequalities in access to care.

These types of need interact in multiple ways. For example, where people have a normative need for dental care, and there are services available to meet that need, but they do not want treatment, they are unwilling recipients and will not present for treatment or accept referral. Where, on the other hand, there is a need and demand but insufficient service capacity to meet that need, waiting lists will grow. Where there is demand and supply but no normative need, such as the referral criteria are not met, patients may seek private treatment.

These interactions are expanded on in figure below.

The relationship between different types of need

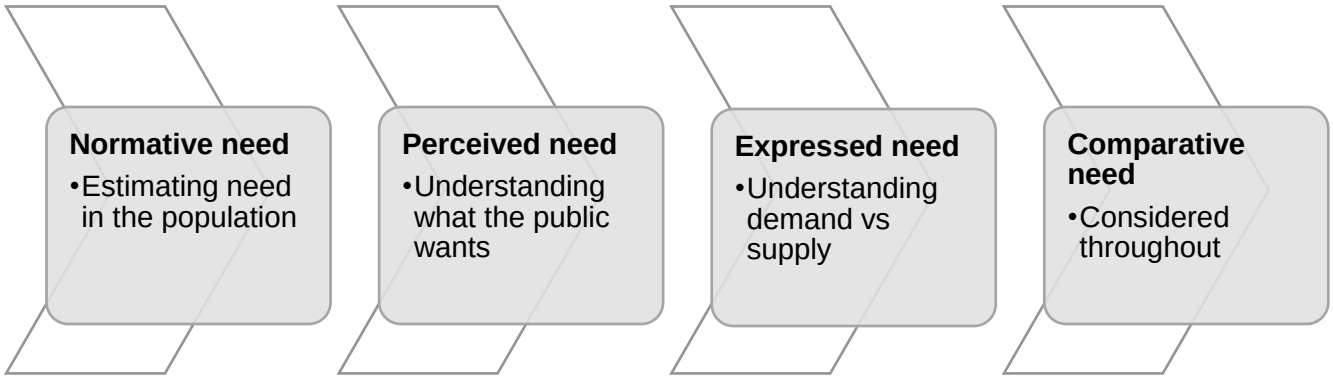


Source: Stevens A, Raftery J, Mant J. An introduction to HCNA from website https://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4c-equality-equity-policy/concepts-need-sjustice

Need, demand and supply overlap, creating seven different fields:

- Field 1: Services are needed but not demanded or supplied
- Field 2: Services are demanded but not needed or supplied
- Field 3: Services are supplied but not demanded or needed
- Field 4: Services are needed and demanded but not supplied
- Field 5: Services are supplied and demanded but not needed
- Field 6: Services are needed and supplied but not demanded
- Field 7: Services are needed, demanded and supplied

For the purposes of this needs assessment we have interpreted the different types of need as follows:



3. Population groups that require Special care or Paediatric dental care

3.1. What do we mean by special care and paediatric dentistry?

A wide range of patients are served by special care and paediatric dental services. These patients can be broadly divided in two groups:

1. People with additional needs – routine dentistry on complex patients
2. People who require complex dentistry but who do not have additional needs

'Additional needs' is used to describe people who experience any of various difficulties (such as a physical, emotional, behavioural, or learning disability or impairment) that causes an individual to require additional or specialised services or support.

Special care dentistry deals with the first group of patients whereas paediatric dentistry deals with patients in both groups.

Where appropriate children with additional needs will transition to special care services once they pass the age of 16. Whereas children requiring complex dentistry will usually transition to specialist restorative services or other specialist services, if not appropriate for care within primary care services.

Additional needs	Complex Dentistry
Moderate to severe learning disabilities	Children with developmental conditions e.g. hypodontia, amelogenesis imperfecta, etc.
Physical disabilities	Children with clefts, syndromes, genetic abnormalities
Communication impairment	Looked after children with complex problems
Progressive cognitive disease	Children with open apices that need endodontic treatment e.g. due to trauma,
Unstable/uncontrolled mental health issues	
Complex medical conditions (ASA4+)	
Obesity plus co-morbidity	
Homeless	
Substance abuse plus medical problems	
Children who are too young to co-operate with dental treatment	

For the purposes of this commissioning process, Managed Clinical Networks in the South East were asked to agree which groups they considered to be ‘core’ to their service. The agreed list (below) was used as the population for this needs assessment.

Special Care Dentistry	Paediatric Dentistry
Moderate to severe learning disabilities	Moderate to severe learning disabilities
Physical disabilities	Physical disabilities
Communication impairment	Communication impairment
Progressive cognitive disease	Severe chronic mental health conditions, e.g. ADHD, eating disorder
Unstable/uncontrolled mental health issues	Severe dental anxiety
Complex medical conditions (ASA4+)	Complex medical conditions (ASA4+)
Obesity plus co-morbidity	Clefts, syndromes, genetic abnormalities
Homeless	Looked after children with complex problems
Substance abuse plus medical problems	Children with open apices that need endo, hypodontia, amelogenesis imperfecta, etc.

3.2. Oral health in people with additional needs

People who are socially disadvantaged, or who have additional needs, tend to have poorer health and poorer access to health care services.[1] These groups are particularly at risk of suffering from oral diseases. The same patterns are seen in all disadvantaged groups: people tend to experience more dental decay, periodontal (gum) disease, tooth loss and edentulousness (no teeth). They also have more unmet need for treatment than more advantaged groups.

The groups that carry the greatest burden of oral diseases are usually disadvantaged in other ways. For example:

- Adults from the most deprived areas, in most age groups, less likely to attend a dentist regularly and are more likely to have decayed teeth, no teeth, gum disease, oral cancer and suffer from urgent conditions**Error! Bookmark not defined.**
- People who have a learning disability experience more oral disease and have fewer teeth than the general population. They also have greater unmet dental needs[2] as they have more difficulty in accessing dental care.[3] Access to oral health care is affected by where people with learning disabilities live: evidence suggests that adults with learning disabilities living in the community have greater unmet oral health needs than their residential counterparts and are less likely to have regular contact with dental services.[4]
- People with mental illness have a greater risk of experiencing oral disease and have greater oral treatment needs.[5] There is a complex interrelationship between socio-economic factors, illness, its treatment and oral health. Illness, whether physical or mental may lead to deterioration in self-care, and oral care may already have a low priority. It is important to ensure that individuals have sufficient information and support in order to live independent lives including oral self-care and access to appropriate dental services.[5]
- Gum disease, tooth decay and oral cancers are more common with age. Older people are increasingly keeping their own teeth, which makes them more likely to have complex dental needs. Older people living in care homes have poorer oral health than other adults. Older people are less likely to access NHS dental services. There is emerging evidence, e.g. from recent Healthwatch[6] and CQC[9] reports, that people living in care homes have a large amount of unmet oral health need.

People with complex needs often carry a heavy burden of:

- More than one type disadvantage, e.g. worklessness, poverty and chronic health conditions.
- Requirement to navigate multiple care pathways that cross disciplinary and organisational boundaries.[7]

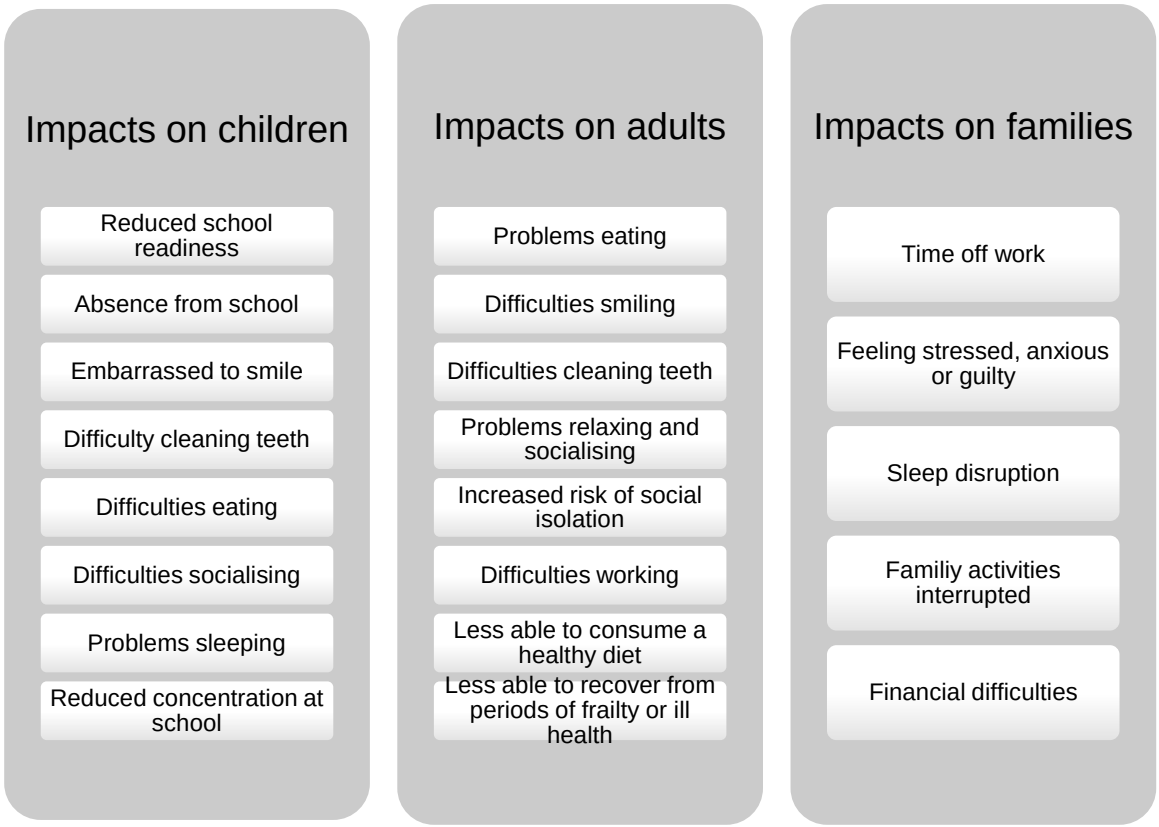
3.3. The importance of oral health for adults and children with additional needs

Oral health, or having a healthy mouth, allows us to eat, drink, speak, smile and communicate. Having a healthy mouth is fundamental to our wellbeing and our ability to live a full life. The impacts of oral diseases are multiple, affecting both physical and psychological wellbeing. There is also increasing evidence that poor oral health has links to several systemic conditions such as diabetes, cardiovascular disease, Alzheimer's disease and aspiration pneumonia. These effects can have a greater impact on an individual with additional needs such as those who are medically complex or frail and elderly.

Poor oral health occurs when we experience diseases of the mouth, like tooth decay, gum disease and oral cancers. Oral diseases are largely preventable but are still among the most commonly found chronic diseases.[8] However, poor oral health can also occur when our mouths are in poor condition, which may or may not coincide with a disease. This can happen when someone's mouth gets too dry (e.g. when an older person is taking multiple medications), when our mouths are not kept clean or when even with minor injuries (e.g. broken teeth rubbing against the gum causing ulcers). These experiences can have a significant impact on a person's health and wellbeing.

At the individual level of it is well known that oral diseases cause tooth loss, pain, sensitivity, infection and, in extreme cases, a threat to life. Less well known perhaps, are the hidden costs (that often have an impact on families, see figure below) and the impact on adults with additional needs.

Figure: The impacts that an unhealthy mouth can have on children, adults and families


Impacts on children
Reduced school readiness
Absence from school
Embarrassed to smile
Difficulty cleaning teeth
Difficulties eating
Difficulties socialising
Problems sleeping
Reduced concentration at school
Impacts on adults
Problems eating
Difficulties smiling
Difficulties cleaning teeth
Problems relaxing and socialising
Increased risk of social isolation
Difficulties working
Less able to consume a healthy diet
Less able to recover from periods of frailty or ill health
Impacts on families
Time off work
Feeling stressed, anxious or guilty
Sleep disruption
Familiy activities interrupted
Financial difficulties

4. Understanding supply

The aim of this part of the needs assessment was to understand the current supply of care to the target groups. The intention was to find out what services are currently provided, where and for whom.

4.1. Methods used

The Dental Public Health team collaborated with the Managed Clinical Networks to agree an approach. An electronic survey was the preferred method to gather data.

A template was created by DPH network and agreed with commissioners, which was then tested with two clinical directors from CDS in the South East. The template was sent electronically to all clinical directors, in August 2017, with 3 week deadline for return. Late submissions added in final version April 2018

Please note: this work was carried out across the South so includes data from services in the South West as well as the South East.

4.2. Findings

Findings are discussed briefly below. The accompanying slide set gives the complete results.

There are currently 18 providers of special care and paediatric dentistry across the South of England

Local office geography	Number of current providers*
Wessex	2
Thames Valley	3
Kent, Surrey and Sussex	7
South West	6

*The number of providers does not equal the number of contracts. Some providers hold more than one contract.

4.2.1. A wide variation in services offered

The table below shows a wide variation in services offered by different providers. Where consistency is seen in the types of services this supports the idea that these services are 'core' to special care and paediatric dental care.

Type of service offered	Provider response*	
	Yes	No
Non-specialist paeds	20	1
Domiciliary care	18	3
Types of sedation provided for under 12s	19	2
Types of sedation provided for over 12s	19	2
Restorations under GA for children with special needs	20	1
Extractions under GA for children with special needs	20	1
Extractions under GA for adults with special needs	19	2
Restorations under GA for adults with special needs	19	2
Endodontics under sedation	17	4
Extractions under GA for children without special needs	18	3
Bariatric patients	18	3
Multidisciplinary (dental) care	17	4
Dental access services in hours	13	8
Treatment of child requiring paeds specialist	12	9
Alternative anxiety management techniques (CBT, acupuncture, etc.)	12	9
Other specialist services (please list)	11	10
Endodontics under GA	12	9
Dental access services out of hours	11	10
In-patient GAs	8	12
Orthodontics	7	14

*the number of responses is greater than the number of providers as some providers submitted separate responses for each of their contracts

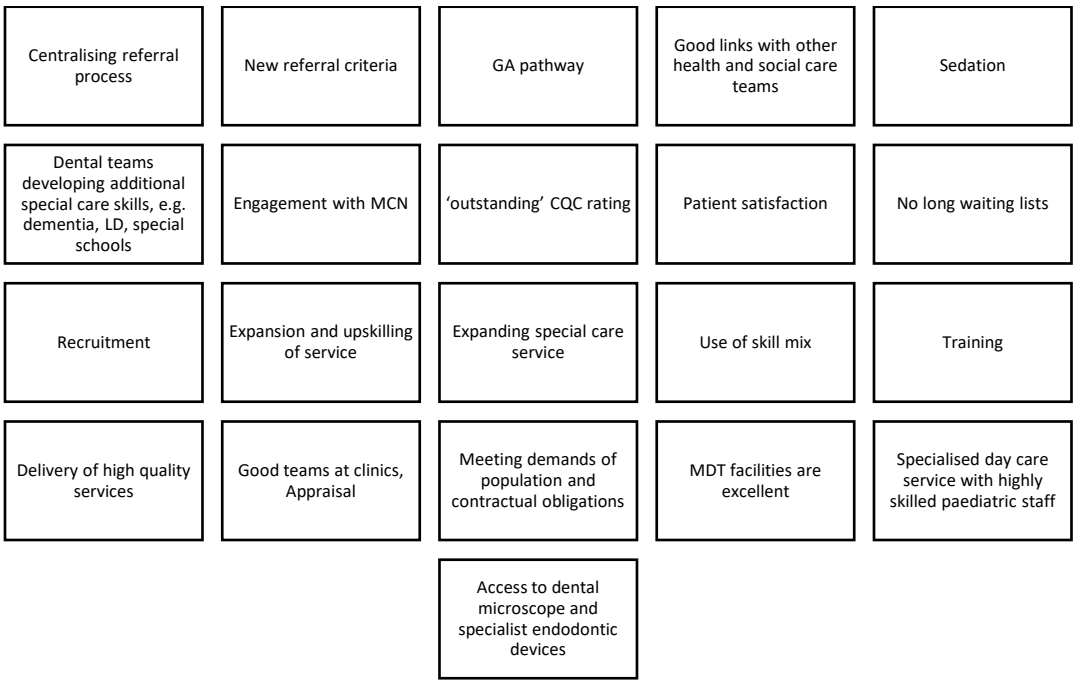
Wide variation was also seen in the size of services and the patient groups seen.

4.2.2. Variation in contracting arrangements

Responses showed variation in current contracting arrangements with some services reporting multiple contract types. There appeared to be confusion around what current contract types, and contract currencies are.

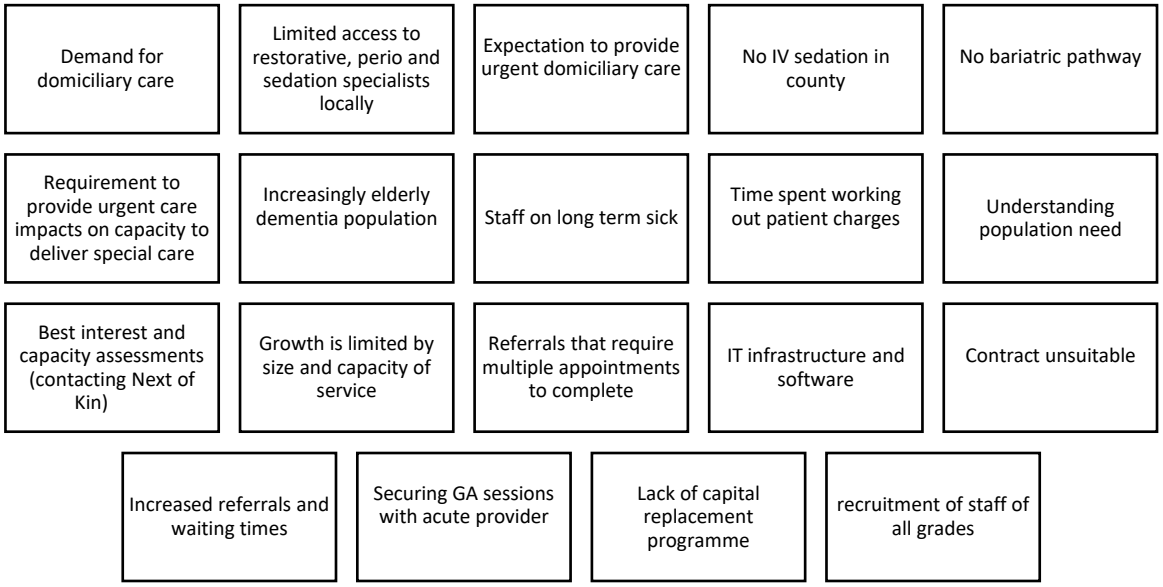
4.2.3. What is currently going well

Things that were going well are listed below. As with the rest of the data, these were self-reported and varied by provider.



4.2.4. What is currently going less well

Things that were going less well are listed below. As with the rest of the data, these were self-reported and varied by provider. for



4.2.5. Other findings

Some questions interpreted differently by responders; waiting times, % cases low complexity and referral data which made it difficult to compare findings between providers

Case mix tool not consistently applied, and reportedly out of date

The majority of services are submitting FP17s and collecting patient charges

4.2.6. Identified risks

Some risks identified through this work are listed below:

There is no security of GAs provision as theatre space often provided on gentleman's agreement, and increasingly in demand from medical specialities which often take priority.

The estate from which these services are delivered is complex

TUPE could apply to around 800 staff members (includes admin staff)

Patient groups not included in any future spec could fall through the gap between GDS and CDS, e.g. children with high caries, bariatric patients

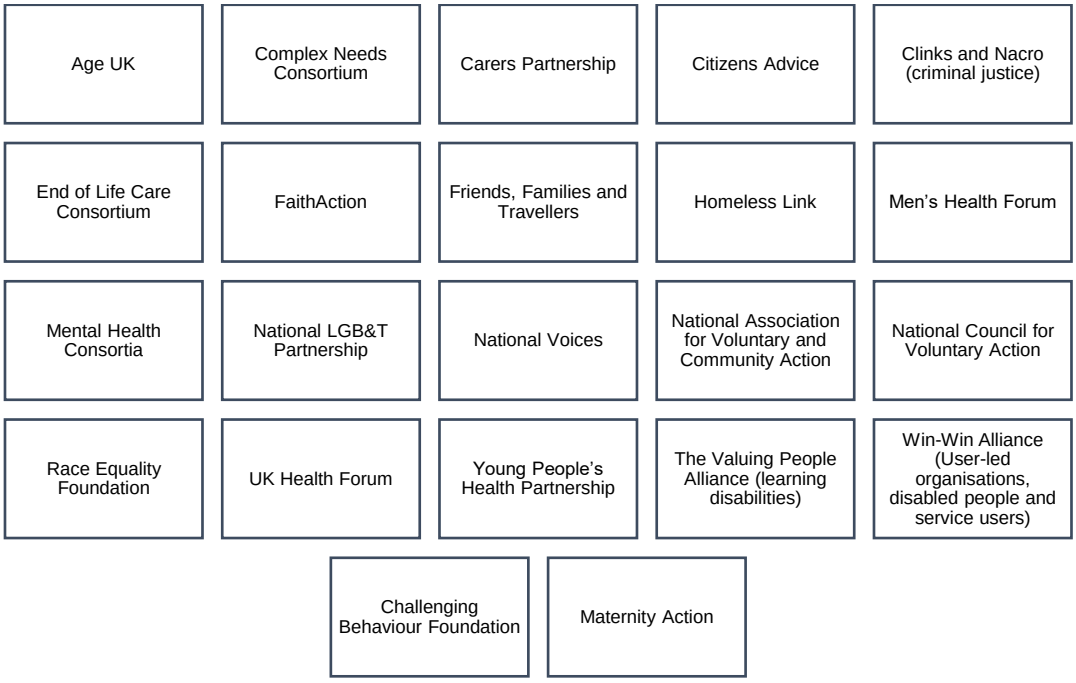
Where shared care arrangements are recommended, there is a need to ensure GDPs are equipped, supported and willing to get involved

5. What the public wants

5.1. Who we engaged with

When determining who and how to engage with we went to the expert Public Engagement Team in Public Health England who suggested working with the Health and wellbeing Alliance. The Health and Wellbeing Alliance, a partnership between the Department of Health, NHS England, Public Health England and the voluntary sector. exists to be a bridge between the voluntary sector, the health and care system, and the people who use it. It aims to ensure high quality services which improve health and wellbeing, respond fairly and effectively to all communities, and give people a strong voice.

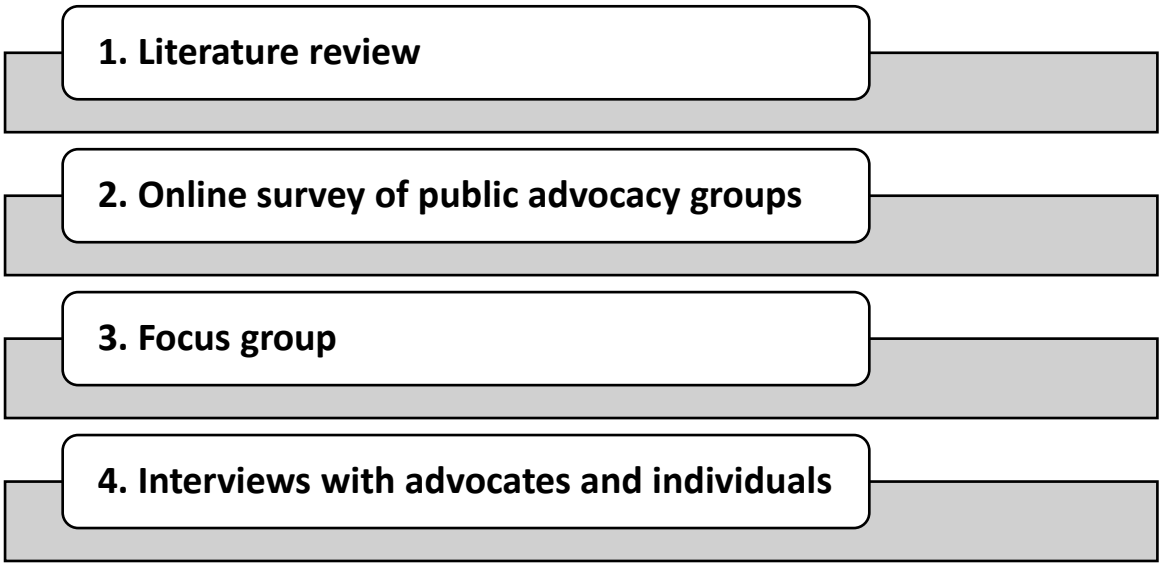
All of the groups listed below were asked to contribute to the public engagement work.



We worked with the Health and Wellbeing alliance through a webinar in the first instance, and this formed the foundation from which the other elements of the public engagement flowed. For example, the alliance helped with question design and facilitated sending and publicising the online survey to its group members. They were also the route through which the focus group was commissioned.

5.2. Methods used

A variety of methods were used to gather as much data as possible on these groups.



There was an awareness throughout that no single method would be comprehensive. Instead multiple methods were used so that the results could be triangulated.

5.3. What we were trying to find out

The first step in the public engagement exercise was to define what information would be most helpful to inform the commissioning process. The following 3 questions were developed through a process that included:

- Seeking advice from public engagement expert
- Discussion with CsDPH and NHSE
- Webinar with Health and Wellbeing Alliance advice

Please note this work did not involve patients: patients will be engaged with as part of the wider engagement work as part of pre-procurement planning.

1. What are the top 3 most important things that would make it easier for you to see a dentist?

2. What are the top 3 most important things to you when you are at your dental appointment?

3. What are the top 3 most important things that prevent you from seeing the dentist?

5.4. Findings

The findings are summarised below into themes however, there is much more detail that is worth exploring, in the accompanying slide sets.

5.4.1. What people with additional needs want from the service offer

- A service that is run by a well-trained workforce
- A workforce that is committed to supporting vulnerable people
- To see the same clinical team at each visit
- To be treated an environment suited to people with additional needs
- A service that collaborates with other teams who support the individual, e.g. other health and social care teams
- Clinics in an accessible location near public transport (some respondents more prepared to travel than others)
- Different models of care if needed, e.g. domiciliary care for bed bound
- Efficiently run, e.g. minimal waits, phone answered quickly, timely access to appointments and information
- A service that recognises that one size does not fit all and is willing and able to provide a flexible approach
- With understanding that people with additional needs will have' good and bad days'. They will be unable to attend appointments on 'bad' days and don't want to be penalised for this.
- A service that collaborates well with other services involved in each patient's care

> Courtesy and respect, being treated as equals, as individuals and as people who make their own decisions. [public voice]

5.4.2. How people with additional needs want to be treated

- With an approach that is customised to them
- With compassion, respect and dignity
- To be spoken to in a calm and caring manner
- Without judgement, e.g. if they struggle to keep their teeth clean
- To be given time to talk and share anxieties
- To be given time to acclimatise to a new environment (particularly important for people with severe learning disabilities)
- To be given choices, e.g. in what treatment they have and how they are communicated with.
- With consideration for their protected characteristics and culture
- For all staff members to behave in the above ways. Reception staff were often mentioned as uncaring and their approach can have a huge impact on patients and their willingness to attend.

> How they deliver that skill set is more important than the skill set as such [public voice]

5.4.3. Flexibility

- Flexibility came up repeatedly as a theme
- People want to be offered choice and options, for example:
- Appointment times and days (including evening and weekends)
- Communication methods (online, by phone, etc)
- Booking methods (online, by phone, etc)
- Cancellation methods (online, by phone, etc)
- Treatment models (domiciliary, outreach, one stop shop, etc.)
- Environment (e.g. quiet spaces)

> I have been in pain with a bad tooth for 8 years now because I am housebound and bedridden and there is no proper dentistry service for people in my position. I am aware that another county has a fully equipped mobile unit but they were not willing to extend the service to my county. [public voice]

5.4.4. Approach customised to individual

This was a theme that was raised repeatedly

For people with severe learning disabilities preparatory work is crucial and can take significant time and planning, e.g. acclimatisation visits, online photos and stories. This is a significantly different approach to people with less severe needs.

> Not being able to get an appointment later in the day [is a barrier] when I can make it and my husband, who is my carer, can get out of work [public voice]

5.4.5. Ask patients about what matters to them

Ask people questions that matter to them, in particular “have your needs been met?”

> I went to the same dentist for 10 years, but I was never asked what the experience was like for me. [public voice]

5.4.6. Build relationships with staff

People want their dental service team to:

- **Get to know them**
- Ask about their additional needs
- Remember what people’s additional needs are from one visit to the next.
- Refer to these needs when planning care without having to be reminded e.g. if a downstairs surgery is required don’t book an appointment in an upstairs one
- Staff need to genuinely care and show it

> Ability to trust somebody, knowing you’re going to get good treatment, is the most important thing [public voice]

5.4.7. Recognise the resources needed, outside of clinical time, to support people with severe additional needs to attend

- Planning is crucial for these patients, particularly someone with severe learning disabilities
- Very important to keep records of the person's needs and what's worked for them previously
- Talk to family in advance to find out what works for that person. Perseverance is key – it might take a number of tries before the right approach is found that works for the individual
- Sometimes need to go 'a bit further', e.g. sedation in the car before they come inside.
- Understand that if people can't attend because they're having a bad day and that they shouldn't be penalised for this.
- Need to find ways to show patients what to expect well in advance, e.g. customisable picture stories and social stories on website

> What surprises me is that this dentist has been available to me for at least five years, and I didn't know existed. [public voice]

5.4.8. Make Special Care more visible, accessible and identifiable

Most people who responded had never heard of CDS, salaried services or Special Care services and don't how to access it

'Special care' is a term that means nothing to most users and is offensive to some

Most people seem to identify with the term 'additional needs' and the focus group members agreed that 'additional needs dental care' could work

> Wouldn't it be better to call them additional care dentists, not special? Too much like special needs education. Special needs is different and very alienating. [public voice]

People with milder additional needs would like to see Special Care expertise in general dental practice, e.g. specialist works out of high street practice once a week.

6. Estimating need and demand

This section focuses on estimating need and demand by using a combination of public health data and current special care and paediatric dentistry data. There are limitations as to what conclusions can be drawn here – it is intended only to give an estimation of levels of need in the population: where it might be higher or lower.

6.1. Methods used

This element of the needs assessment began by identifying a 'wish list' of data. We then sought expert advice from the PHE Health Intelligence team as to how realistic this was and how we needed to refine the list. As a result, the final list was has been refined according to:

- What data are routinely collected, e.g. by BSA
- What data are available at CCG and local authority level
- Quality of data
- Relevant population groups with greater oral health needs (like severe dementia)
- Relevant population groups that are growing in size (people aged 85+)
- Population groups that are high profile, in particularly children who have extractions under general anaesthetic
- Groups identified by Special Care/Paediatric Managed Clinical Networks as core to their current service
- The NHS commissioning guides on Special Care and Paediatric NHSE commissioning guides
- Public health data – proxy for normative need
- BSA data – proxy for expressed/demand – activity only.

The key indicators are made up of 2 elements (each with its own set of metrics):

1. Data from public health data sets
2. Data on dental activity of current Special Care and Paediatric dental services (most of which submit data to the BSA)

The final list of metrics is on the next page.

Please note due to recent reorganisation of CCGs in Thames Valley and Wessex, there are two sets of CCG metrics for this area only.

Local Authority Indicators	CCG (2018/19) indicators	CCG (2017/18) indicators (HTV only)	BSA activity data
Disability free life expectancy for males (2009-2013)	Depression: % patients recorded on practice disease registers (aged 18+) (QOF prevalence) (2017/18)	Estimated prevalence of any mental health disorder: % GP registered population aged 5-16 (2015)	Total number of patients treated (general) - resident in LA
Disability free life expectancy for females (2009-2013)	Care home beds (nursing and residential) per 100 people 75+ (2018)	Children with one or more decayed, missing or filled teeth: % of Oral Health Survey responders (5yrs) (2016/17)	Total number of patients treated (general) - not resident in LA
Percentage ethnic minorities (16+yrs) (2016)	Learning disability: % of all patients recorded on practice registers (all ages) (2017/18) (QOF prevalence)	Mean number of dentinally decayed, missing due to dental decay and filled teeth among those with any decay experience (5yrs) (2016/17)	Total number of patients in contracts
Total resident population (2016)	Dementia: % of all patients recorded on practice registers (all ages) (QOF prevalence)(2017/18)	Deprivation score (IMD 2015)*	% total number of patients treated (general) - resident in LA
Children in low income families: % of children under 16s in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income (2016)	Long-standing health condition: % of GP patient survey responders who reported having a long-term physical or mental health condition, disability or illness (16+yrs) (2018)	% Older People Income Deprivation 60+yrs (IDAOPI) (2015)	% total number of patients treated (general) - not resident in LA
Children with Profound & Multiple Learning Difficulty known to schools per 1000 pupils (2018)	Deafness or hearing loss: % of GP patient survey responders who reprted having deafness of hearing loss (16+yrs) (2018)	Population estimates 2019 (based on 2016 population figures)	Adult patients treated by contract
		Population estimates 2030 (based on 2016 population figures)	Number of patients treated by age
			Number and proportion of patients treated in each deprivation quintile

These metrics will need to be assessed together to give an overall estimation of need in an area. The data are reported at the smallest geography for which they were available, with CCG as a preference where possible.

6.2. Findings

Presented below is a sample of the data collected that can be used to estimate need and demand for Special Care and Paediatric dentistry in the population. The full data set is available as a separate spreadsheet.

6.2.1. Making sense of the data

6.2.1.1. Navigating this section

The data are presented below in two sections: one focused on public health data (6.2.2) and one on the dental activity data (6.3.3). The public health data sets are further split into two sections; one focused on Thames Valley and Wessex and one on Kent, Surrey and Sussex. Each section is broken down into deprivation, local authority data and CCG data.

Please note: due to the number of CCGs or LAs in each patch, you will find the tables have been split into two to enable them to fit on a single page. To reduce the number of decimal points, data have been rounded up and down.

6.2.1.2. Tirtiles and colour coding

To help make sense of the public health the values against each metric have been colour coded by tirtile. This means that the results have been split into thirds, as shown in the key below.

KEY

	Tirtile likely to have less oral health need
	Middle tirtile
	Tirtile likely to have more oral health need

6.2.1.3. Deprivation data

The English Indices of Deprivation 2015 use 37 separate indicators, organised across seven distinct domains of deprivation which can be combined, using appropriate weights, to calculate the Index of Multiple Deprivation 2015 (IMD 2015). This is an overall measure of multiple deprivation experienced by people living in an area. The higher the deprivation score, the more deprived the area.

There is a well-established association between general ill health, oral diseases and deprivation. This means that populations living in areas with a higher IMD score are more likely to experience poor oral and general health. Deprivation is represented by the IMD score calculated for each CCG. The IMD score is a measure of the relative deprivation of the local population when compared to the national picture. This is an average score and therefore does not show the variation in deprivation seen within the population. This means that in the South East there are many pockets of deprivation in more affluent areas that may not be represented by the IMD score.

6.2.1.4. Local authority (LA) and CCG data

The LA and CCG data in this summary has been selected from the larger dataset as these measures, taken as a whole, are the most likely to indicate need for Special Care and Paediatric dental services. Figures have been rounded up/down to aid interpretation.

6.2.1.5. Special Care and Paediatric dental services activity data

This section reports data by contract and covers all services in the South East except for the two services which do not submit FP17 data to the BSA, namely Brighton and Sussex University Hospitals NHS Trust and Surrey and Sussex Healthcare NHS Trust.

6.2.2. Thames Valley and Wessex Data

6.2.2.1. Deprivation data (TV and W)

CCG 2017/18 indicator	NHS Aylesbury Vale CCG	NHS Bracknell and Ascot CCG	NHS Chiltern CCG	NHS Dorset CCG	NHS Fareham and Gosport CCG	NHS Isle Of Wight CCG	NHS Newbury and District CCG	NHS North and West Reading CCG	NHS North East Hampshire and Farnham CCG	NHS North Hampshire CCG
Deprivation score (IMD 2015)	10.8	9.7	9.1	16.4	13.6	23.1	11.1	10.7	9.9	10.7

CCG 2017/18 indicator	NHS Oxfordshire CCG	NHS Portsmouth CCG	NHS Slough CCG	NHS South Eastern Hampshire CCG	NHS South Reading CCG	NHS Southampton CCG	NHS West Hampshire CCG	NHS Windsor, Ascot and Maidenhead CCG	NHS Wokingham CCG
Deprivation score (IMD 2015)	11.6	27.1	22.9	15.9	22.3	26.9	10.6	9.5	5.7

The IMD scores across Thames Valley and Wessex show that this is generally an affluent population, with 15 of the 20 CCGs have an IMD score below the England average of 21.8. Wokingham CCG for example, has an IMD score of 5.7 which is well below the England average and is the lowest in the South East. Five CCGs in Thames Valley and Wessex however, have IMD scores above the England average including:

- Portsmouth
- Slough
- Isle of Wight
- Reading
- Southampton.

6.2.2.2. Local authority data (TV and W)

Local Authority Indicators	Oxfordshire	West Berkshire	Reading	Wokingham	Bracknell Forest	Slough	Windsor and Maidenhead	Bucking-hamshire
Percentage ethnic minorities (16+yrs) (2016)	9.5	4.9	21.0	6.6	7.6	54.6	13.9	12.8
Total resident population (2016)	678,484	158,576	162,701	163,087	119,730	147,736	149,689	533,056
Children in low income families	10.3	9.1	15.7	6.4	9.1	15.1	7.9	9.5
Children with Profound & Multiple Learning Difficulty known to schools per 1000 pupils (2018)	1.0	1.5	0.6	0.8	0.5	0.9	1.0	0.6
Looked after children: rate per 10,000 population aged under 18 (2018)	48	41	75	27	49	49	31	39
Rate of children in need during the year, per 10,000 aged <18 (2014/15)	476	546	765	291	527	946	477	626
Statutory homelessness: rate of households eligible, unintentionally homeless and in priority need per 1,000 households (2017/18)	1.1	0.2	3.7	1.4	1.5	5.4	0.9	1.8

Local Authority Indicators	Hampshire	Southampton	Portsmouth	Isle of Wight	Bournemouth	Dorset	Poole
Percentage ethnic minorities (16+yrs) (2016)	4.4	14.8	8.8	1.8	7.3	1.5	3.4
Total resident population (2016)	1,365,103	250,377	213,335	140,264	193,653	422,933	150,711
Children in low income families	10.3	20.1	20.4	18.8	16.4	12.5	14.4
Children with Profound & Multiple Learning Difficulty known to schools per 1000 pupils (2018)	0.8	1.8	1.1	1.9	1.0	0.5	2.2
Looked after children: rate per 10,000 population aged under 18 (2018)	56	104	94	90	68	59	65
Rate of children in need during the year, per 10,000 aged <18 (2014/15)	581	1227	722	1239	945	686	922
Statutory homelessness: rate of households eligible, unintentionally homeless and in priority need per 1,000 households (2017/18)	1.2	2.5	5.3	1.2	3.8	1.6	1.6

There are 5 local authorities in Thames Valley and Wessex with four or more metrics in the higher need tirtile. These are:

- Southampton
- Portsmouth
- Isle of Wight
- Bournemouth
- Reading

There appears to be an association between the level of deprivation (IMD score) of the CCGs and the local authorities that have the greatest number of metrics that fall into the higher need tirtile.

6.2.2.3. CCG data (TV and Wessex)

CCG (2018/19) indicators	NHS Berkshire West CCG	NHS Buckingha mshire CCG	NHS Dorset CCG	NHS East Berkshire CCG	NHS Fareham and Gosport CCG	NHS Isle Of Wight CCG	NHS North East Hampshire and Farnham CCG
Care home beds (nursing and residential) per 100 people 75+ (2018)	9.3	9.6	9.7	8.1	10.6	12.2	10.2
Learning disability: % of all patients recorded on practice registers (all ages) (2017/18) (QOF prevalence)	0.4	no data	0.5	0.3	0.4	0.7	0.3
Dementia: % of all patients recorded on practice registers (all ages) (QOF prevalence) (2017/18)	0.6	no data	1.0	0.6	0.9	1.3	0.7
Long-standing health condition: % of GP patient survey responders who reported having a long-term physical or mental health condition, disability or illness (16+yrs) (2018)	47.7	47.1	54.2	47.1	55.0	62.0	49.8

CCG (2018/19) indicators	NHS North Hampshire CCG	NHS Oxfordshire CCG	NHS Portsmouth CCG	NHS South Eastern Hampshire CCG	NHS Southampton CCG	NHS West Hampshire CCG
Care home beds (nursing and residential) per 100 people 75+ (2018)	9.9	9.6	10.0	11.0	10.2	10.1
Learning disability: % of all patients recorded on practice registers (all ages) (2017/18) (QOF prevalence)	0.4	0.4	0.4	0.5	0.5	0.4
Dementia: % of all patients recorded on practice registers (all ages) (QOF prevalence) (2017/18)	0.7	0.8	0.7	1.1	0.6	1.0
Long-standing health condition: % of GP patient survey responders who reported having a long-term physical or mental health condition, disability or illness (16+yrs) (2018)	51.3	48.3	50.9	54.2	50.3	53.9

There are 3 CCGs in Thames Valley and Wessex with three or more metrics in the higher need tirtile. These are:

- South Eastern Hampshire
- Dorset
- Isle of Wight

Please note: there are two metrics in Bucks for which there are no data (% learning disability and % dementia). This is because there are no data for the newly formed Buckinghamshire CCG geography, as yet.

6.2.3. Kent, Surrey and Sussex

6.2.3.1. Deprivation data (KSS)

CCG 2017/18 indicator	NHS Ashford CCG	NHS Brighton and Hove CCG	NHS Canterbury and Coastal CCG	NHS Coastal West Sussex CCG	NHS Crawley CCG	NHS Dartford, Gravesham and Swanley CCG	NHS East Surrey CCG	NHS Eastbourne, Hailsham and Seaford CCG	NHS Guildford and Waverley CCG	NHS Hastings and Rother CCG
Deprivation score (IMD 2015)	17.3	23.4	17.3	15.8	17.8	18.8	11.2	18.0	8.3	25.8

CCG 2017/18 indicator	NHS High Weald Lewes Havens CCG	NHS Horsham and Mid Sussex CCG	NHS Medway CCG	NHS North West Surrey CCG	NHS South Kent Coast CCG	NHS Surrey Downs CCG	NHS Swale CCG	NHS Thanet CCG	NHS West Kent CCG	NHS Surrey Heath CCG
Deprivation score (IMD 2015)	12.1	8.3	22.3	10.7	22.7	8.0	27.2	31.6	12.4	8.9

The IMD scores across Kent, Surrey and Sussex show that this is generally an affluent population, with 6 of the 19 CCGs have an IMD score below the England average of 21.8. Surrey Downs CCG for example, has an IMD score of 8.0 which is well below the England average and is the lowest in KSS. Six CCGs in Kent, Surrey and Sussex however, have IMD scores above the England average including:

- Brighton and Hove
- Hastings and Rother
- Medway
- South Kent Coast
- Swale
- Thanet

Thanet has the highest IMD score in the South East at 31.6.

6.2.3.2. Local authority data (KSS)

LA indicators	Surrey	West Sussex	Brighton and Hove	East Sussex	Medway	Kent
Percentage ethnic minorities (16+yrs) (2016)	8.9	4.5	11.2	3.2	9.2	5.1
Children with Profound & Multiple Learning Difficulty known to schools per 1000 pupils (2018)	0.9	0.9	1.2	1.1	1.0	1.3
Rate of children in need during the year, per 10,000 aged <18 (2014/15)	525.3	527.1	912.4	739.7	681.0	531.0
Statutory homelessness: rate of households eligible, unintentionally homeless and in priority need per 1,000 households (2017/18)	1.3	1.7	3.8	2.8	2.2	2.2
Looked after children: rate per 10,000 population aged under 18 (2018)	35.7	40.6	82.0	56.9	64.7	48.9
Total resident population (2016)	1,180,956	846,888	287,173	549,557	276,957	1,540,438

There is only one local authority in Kent, Surrey and Sussex with four or more metrics in the higher need tirtile. This is Brighton and Hove.

6.2.3.3. Kent, Surrey and Sussex data – CCG geography

CCG (2018/19) indicators	NHS Ashford CCG	NHS Brighton and Hove CCG	NHS Canterbury and Coastal CCG	NHS Coastal West Sussex CCG	NHS Crawley CCG	NHS Dartford, Gravesham and Swanley CCG	NHS East Surrey CCG	NHS Eastbourne, Hailsham and Seaford CCG	NHS Surrey Heath CCG
Care home beds (nursing and residential) per 100 people 75+ (2018)	10.3	12.4	12.1	11.4	5.8	8.4	15.9	12.3	14.7
Learning disability: % of all patients recorded on practice registers (all ages) (2017/18) (QOF prevalence)	0.4	0.5	0.5	0.5	0.6	0.3	0.7	0.5	0.4
Dementia: % of all patients recorded on practice registers (all ages) (QOF prevalence) (2017/18)	0.7	0.6	0.9	1.1	0.6	0.6	0.8	1.3	0.8
Long-standing health condition: % of GP patient survey responders who reported having a long-term physical or mental health condition, disability or illness (16+yrs) (2018)	53.2	51.7	52.9	56.0	50.0	49.4	50.2	58.9	49.8

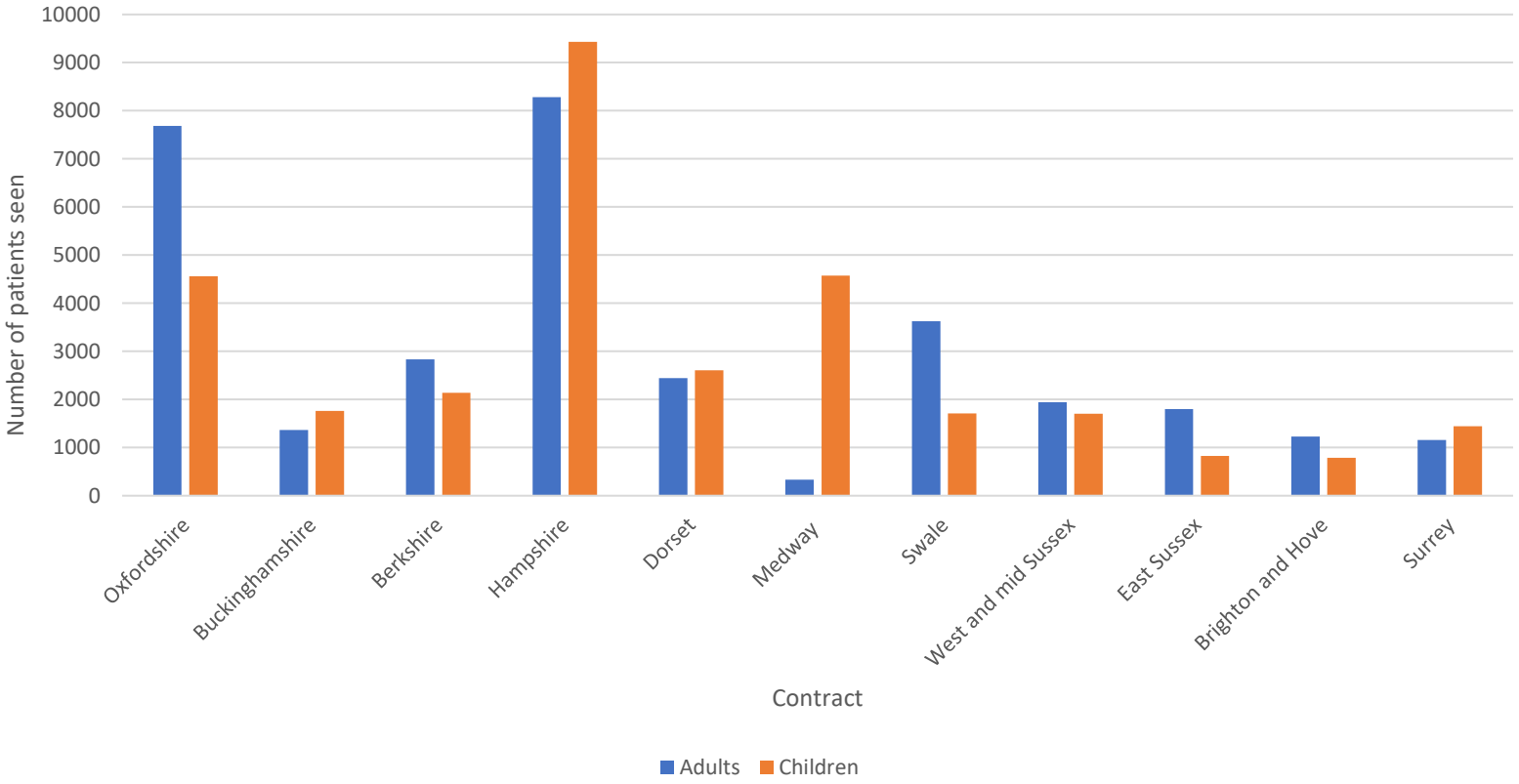
CCG (2018/19) indicators	NHS Guildford and Waverley CCG	NHS Hastings and Rother CCG	NHS High Weald Lewes Havens CCG	NHS Horsham and Mid Sussex CCG	NHS Medway CCG	NHS North West Surrey CCG	NHS South Kent Coast CCG	NHS Surrey Downs CCG	NHS Swale CCG	NHS Thanet CCG	NHS West Kent CCG
Care home beds (nursing and residential) per 100 people 75+ (2018)	11.8	15.5	10.6	13.1	8.7	11.0	13.2	12.8	9.8	10.9	9.7
Learning disability: % of all patients recorded on practice registers (all ages) (2017/18) (QOF prevalence)	0.4	0.7	0.5	0.4	0.4	0.4	0.7	0.4	0.5	0.6	0.4
Dementia: % of all patients recorded on practice registers (all ages) (QOF prevalence) (2017/18)	0.8	1.1	1.0	1.0	0.6	0.8	1.0	0.9	0.7	0.9	0.8
Long-standing health condition: % of GP patient survey responders who reported having a long-term physical or mental health condition, disability or illness (16+yrs) (2018)	46.0	58.0	55.3	53.0	53.2	48.4	57.6	47.8	56.2	58.1	50.4

There are 3 CCGs in Kent, Surrey and Sussex with three or more metrics in the higher need tirtile. These are:

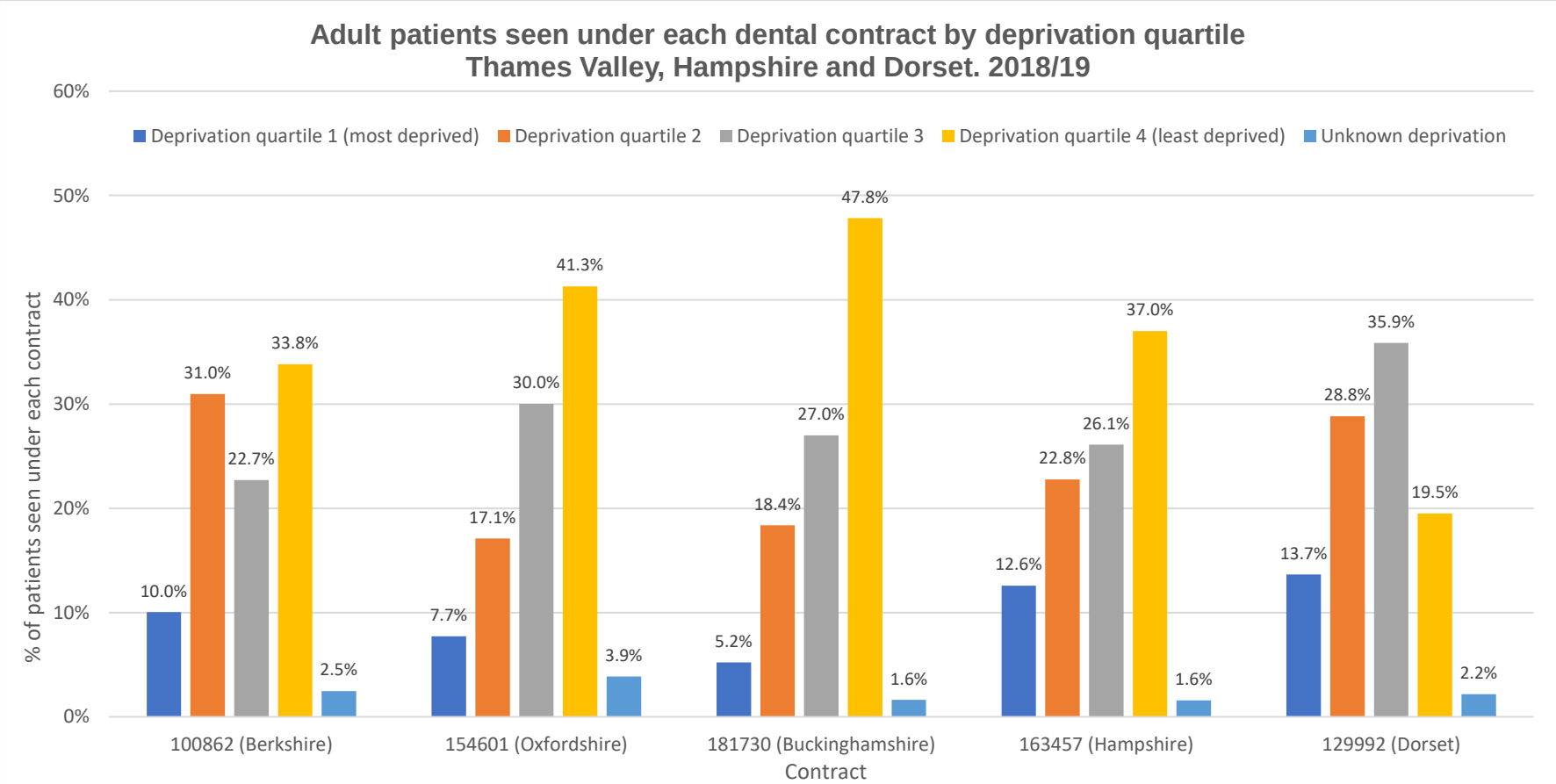
- Hastings and Rother
- South Kent Coast
- Coastal West Sussex

6.2.4. Dental Activity data for current contracts providing Special care and Paediatric dental services

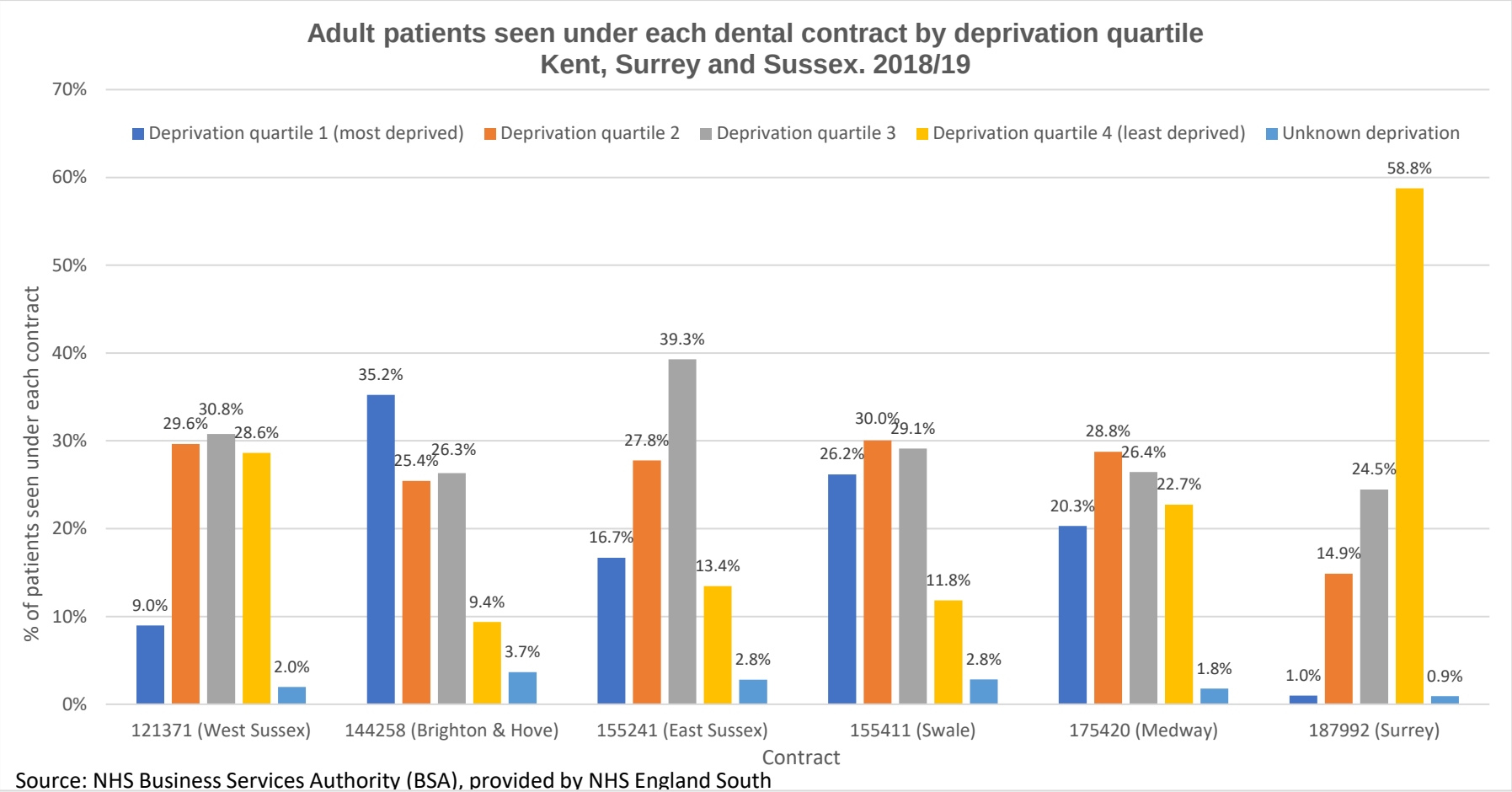
Chart: Number of adult and child patients seen by contract 2017/18



Six of 11 services in the South East treated approximately the same number of adults and children in 2017/18 (Bucks, Berks, Hampshire, Dorset, West and Mid Sussex and Surrey). On the other hand, services in Oxfordshire, Swale, East Sussex, Brighton & Hove treated more adults and children. Medway conversely treated considerably more children than adults.



Source: NHS Business Services Authority (BSA), provided by NHS England South



Source: NHS Business Services Authority (BSA), provided by NHS England South

The proportion of adult patients from each deprivation quartile seen by the services across the South East shows variation between the services. There were five out of the eleven services which had the greatest proportion of patients coming from the least deprived quartile. These were:

- Berkshire
- Oxfordshire
- Buckinghamshire
- Hampshire
- Surrey

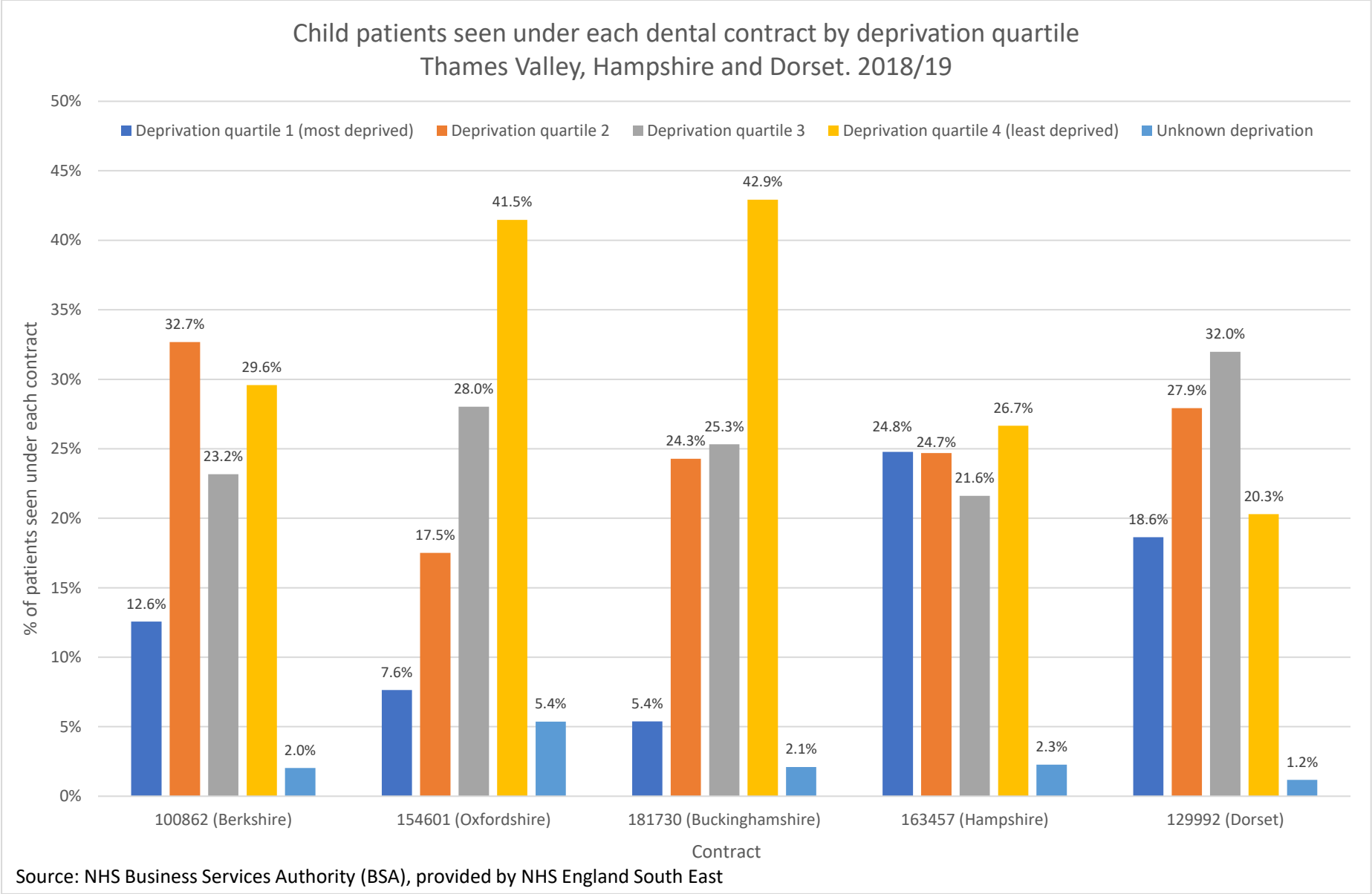
Only one service, Brighton and Hove, had the greatest proportion of adult patients coming from the most deprived quartile.

From the data it is not possible to definitively say why this variation exists. Some possible reasons for it could be:

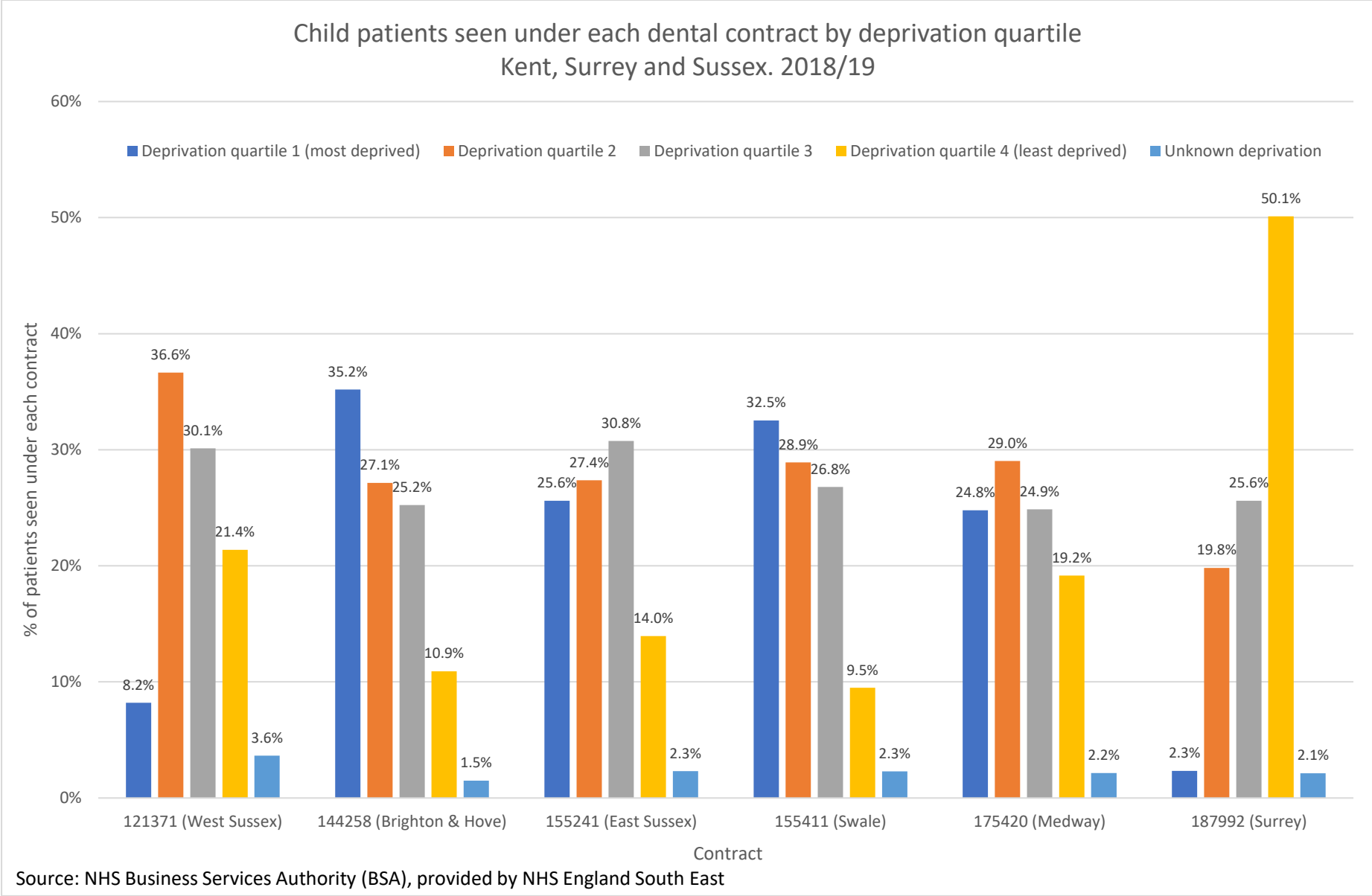
- Accessibility of the service e.g. location, opening hours, public transport links
- The relative deprivation of the area from which the services draw their patients. Surrey for example has some of the lowest CCG IMD scores in the south east and so will have relatively fewer people in the more deprived quartiles in their catchment area than other areas in the South East.
- The capacity of the service
- Awareness of the service by those in deprived populations

Evidence suggests that the proportion of patients with the greatest need for special care/paediatric services is highest in the more deprived quartiles. The activity data suggests that access to the service for those with greatest need could be improved. This pattern of access is likely to be contributing to a widening of health inequalities in vulnerable groups.

The variation in access by deprivation quartile seen for adults is mirrored for access for children.



Source: NHS Business Services Authority (BSA), provided by NHS England South East



Source: NHS Business Services Authority (BSA), provided by NHS England South East

7. Challenges and limitations

There were several challenges with, and limitations to, this work.

7.1. Challenges

Quantifying normative and expressed needs precisely, for Special Care and Paediatric dentistry services, is challenging for a number of reasons:

- There are multiple population groups, each with different characteristics.
- Even within a single group there is no way to predict what type of treatment, or how much treatment, an individual, or group of individuals, will need.
- There is no formula that can predict what proportion of each group will require special care treatment (it varies by individual).
- The treatments that are needed range from a regular check up to restorations under IV sedation to extractions under General Anaesthetic to domiciliary care. There is no way to quantify what will be needed as there is no direct relationship between clinical need and method of treatment, e.g. if a patient with learning difficulties has tooth decay this could be managed in any of these ways – the appropriate choice will be made clinically for each individual and cannot be estimated from data on prevalence of dental disease.
- A wide variety of treatments could be provided in the same individual at different times, for example and adult with a complex medical history could need treatment under GA to begin with, then regular check-ups while their mouth is stable, then domiciliary care during periods of frailty.
- Some individuals will have a single course of treatment while others will need Special Care dentistry for life.
- People with Special Care needs may be less likely to demand care than the parents of children with orthodontic treatment needs.
- Existing services measure demand (expressed need) in a variety of ways which means that there is no valid way to collate the information at a population level.
- All of the people from relevant population groups will fall somewhere on a spectrum of need: at one end of the spectrum, the patient can be treated in GDS, at the other end they will require Special Care dentistry. Also some people will be shared care, some will need a single course of treatment in special care. This means we cannot quantify, say, the number of adults with severe learning disabilities and assume that they will all require Special Care dentistry.
- We did not get much engagement from groups representing children through the Health and Wellbeing Alliance

Taken together, this means that none of the outputs of this needs assessment process is able to give ‘the answer’ to what or how much special care/paediatric dentistry should be commissioned. In this sense this work varies markedly from a more traditional service needs assessment, such as the recent needs assessment for orthodontic services. The table below outlines the differences between the two approaches.

Orthodontics	Special care/Paediatric
Defined population group	Multiple population groups
Single type of treatment	Multiple types of treatment
Single course of treatment	May be single course of treatment, shared care or continuous care
Formula can be used e.g. Stephen's	No formula
Need for care is evenly distributed across population	Some groups have a higher need for specialist-led care than others
Clear parameters for NHS care (IOTN)	No agreed measures for determining who is appropriate for care

7.2. Limitations

- Patients not included, however this is going to be addressed in local engagement work
- Overall few responses from the public engagement work in relation to paediatric care
- Availability of data is limited
- Specificity of data e.g. ideally want to know what % of population are unable to cope with GDS
- No routinely collected data on oral health or disease in people with additional needs.
- Not all groups engaged, e.g. limited responses to online survey
- Limited resources/time to do this work
- Demand data – the usefulness of available data was limited because services gather waiting times in different ways so not comparable
- Impossible to determine whether services currently under or over commissioned as cannot quantify level of met or unmet need in a reliable way

8. Summary of Key Findings

The key findings of this needs assessment are summarised below, by section.

8.1. Understanding supply: key findings

- There are some similarities in what current services provide, e.g. general agreement about which patient groups and which types of treatment provided are considered core to special care/paediatric dentistry
- Variations in how current services provided, e.g. number and size of clinics, capacity in the service, geography covered
- Variation in funding and contracting of current services
- Taken together these findings suggest that there is a postcode lottery for the public as to what is available in each area.
- There are very few paediatric specialists across the South
- Things that are reported to be going less well by multiple providers:
  - Problems with recruitment of specialists, dentists and dental nurses
  - High demand for domiciliary care (urgent and routine)
  - Lack of bariatric care
  - Increased referrals and waiting times
- Key risks to the system:
  - Complex estate
  - No security of provision of treatment under general anaesthetic due to competition for theatre space
  - Potential gaps in the pathway if acceptance criteria become more restricted as it could result in people with milder additional needs being ineligible for treatment in specialist services yet unable to access care in GDS (where treatment of this type of patient is not always felt to be incentivised)

8.2. Understanding public ‘wants’: key findings

- A flexible service that can adapt its approach to the needs of the individual. This varies from smaller issues like communication approaches to larger issues like whether a mobile or domiciliary service is offered.
- Services need to build relationships with patients, treat them with respect, give them choices and establish trust.
- Services need to be easy to access for people with additional needs, including accessible by public transport, extended opening times/days, minimal waits, etc.
- Services need to link to other services that support the individual across health and social care.
- Regularly ask people about what matters to them, in particular ‘have your needs been met?’
- Recognise the resource needed, outside of clinical time, to support people with severe additional needs to attend, such as acclimatisation visits and discussions with carers in advance.
- Services that are visible to the public and named in a way that is meaningful for users, e.g. dental care for people with additional needs.

8.3. Estimating needs and demand: key findings

- The data collected give an overview of the population in the South East. It is not possible however, to quantify the level of need or demand for Special Care and Paediatric dental services.
- The South East is generally less deprived than the England average. There are however 11 CCG areas that are more deprived than the England average, these are spread across TV and Wessex and KSS.
- The public health data also shows variation across the South East. Some local authorities and CCGs are more likely to have higher need within their populations. These are also spread across TV and Wessex and KSS.
- The proportion of adults seen in each deprivation quartile varies between services. Some services stood out because they saw a higher proportion of patients from either the most deprived or the most affluent population groups.
- It would be valuable to better understand the reasons for high proportion of affluent patients being seen by some services

8.4. Other emerging issues

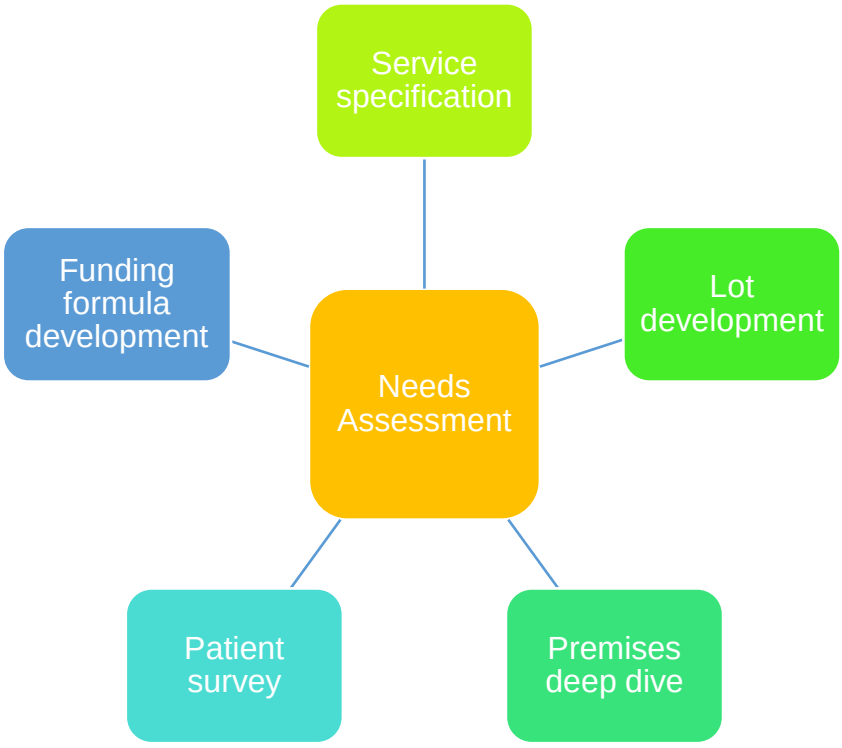
- There is anecdotal evidence, from multiple sources such as a recent CQC report on oral health in care homes[9], of high levels of unmet need in care homes. This is also likely to apply to older people living in their own homes and patients with learning disabilities who rely on a third party for much of their self-care. This supports feedback from current providers that demand for domiciliary care is hugely outstripping supply.
- There is a need to consider the entire pathway for children and people with additional needs.
    - Part of this should involve consideration of how people with mild additional needs, who do not meet the criteria for special care, will receive treatment. If the intention is that they are treated in general dental services, for example, how will we ensure that providers suitable trained, supported and incentivised to see these patients, e.g. provide care for those living in care homes that do not require domiciliary care. Pathways for paediatric and special care need to link to wider social care and health networks e.g. PCNs.
    - The wider developments in the health and social care system, as a result of the NHS Long Term Plan, means that there would be value in considering how this pathway can link into the developing system. In particular there are likely to be opportunities across the South East to link into commissioning networks, as part of developing Integrated Care Systems and provider networks, such as Primary Care Networks

- There are some valuable learning about good practise that could potentially be applied to other dental services, for example:
    - Importance of receptionist as gatekeeper: the need to provide excellent customer service and a caring approach
    - All staff to have training in key areas, e.g. disability equality, communication, customer services

- The same clinical team to see patients on an ongoing basis
- Extended opening hours
- Evaluating care: ask people ‘have your needs been met? If not, ask what could have been done differently?’ and audit improvements
- Offer menu of options, e.g. communications suitable for range of needs
- Keep track of people’s additional needs, related ‘reasonable adjustments’ and using it to inform all interactions
- Environment: signage, accessible toilets, quiet spaces, step free access, etc.

8.5. Next steps

These findings will (and have already begun to) inform the other workstreams of the commissioning process, as illustrated in the diagram below.



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