NHS ENGLAND AND NHS IMPROVEMENT

ORAL HEALTH NEEDS ASSESSMENT

SOUTH WEST OF ENGLAND

January 2021

APPENDIX 3
SOMERSET STP ANALYSIS

Ottaway Strategic Management

www.ottawaystrategic.co.uk

NHS England and NHS Improvement
Oral Health Needs Assessment
South West of England

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Appendix 3 Somerset OHNA STP Appendix

Contents

1 Summary

Highlighted oral health needs.

1.1 This appendix to the OHNA for the South West has identified a series of factors that impact on the oral health needs and the provision of dental services in Somerset. These issues relate to the whole population, for example risk factors that determine the oral health of the population, epidemiological research and the context of current provision.

1.2 Additional engagement with stakeholders in the County has taken place, particularly with patients, the general public and providers of oral health services locally. Clear themes emerge from this engagement as well as clear implications for the findings of this local appendix.

1.3 Somerset has a population 559,399 people. Its population consists of more females (51%) than males (49%) - a gender profile that is consistent with the population of England. Compared with England as a whole, there are less people of working age and more people of retirement age. The proportion of children and young people in Somerset is consistent with the national demographic profile. The BAME population in Somerset is 2% compared to 4% in the South West and 14% in England.

1.4 Population growth is a significant factor for oral health services and in particular primary care dentistry, as by 2028 the total population of Somerset will have grown by 7% (an additional 36,993 people), the child population will have declined by -1% (-1,410) and the older adult (65+) population will have grown by 24% (an additional 33,082 people). From an oral health service perspective, this significant increase in the older demographic will result in services needing to meet a greater level of older people's dental needs. The shift in the child population suggests that there will be marginally less child patients, and therefore this is unlikely to impact on the oral health needs of children in the county.

1.5 Since the last Index of Multiple Deprivation, Somerset has seen a slight shift towards greater deprivation relative to the rest of England, particularly in relation to the quality of housing. The number of 'highly deprived' neighbourhoods in Somerset (categorised as being within the 20% most deprived in England) increased to 29 in IMD 2019, up from 25 at the time of IMD 2015. The highest levels of deprivation are found within the county's larger urban areas. The most deprived area of Somerset is the Highbridge South West area of Sedgemoor.

1.6 The mortality rate for cardiovascular disease is lower in Somerset than national and South West rates. The mortality rates for respiratory disease in Somerset are lower

than the rates in England and the South West. The prevalence of diabetes in Somerset (7%) is higher than the South West (6.5%) and England profile (6.9%).

1.7 Most recent data suggests the level of physical activity varies with 65% in Somerset undertaking 150* minutes per week, which is just above the national rate at 64% and below the South West profile of 67%. Inactivity was at 23%, which is below the nation profile at 25% and above the South West profile at 21%.

1.8 Reception Years data from the national child measurement programme shows a consistent proportion of children that are obese and or overweight 22% when compared to national and South West levels. The levels of obese or overweight in the adult population is 66% in Somerset, which is higher than the national (62%) and regional (63%) level. Finally, smoking prevalence in Somerset is 14% which is the same as the national (14.5%) and South West comparators (13.7%).

1.9 The patient and public survey completed as part of this OHNA suggests that 65% of patients travel to their dentist by car. However, there are lower numbers of households with access to a car or van, particularly in rural areas, suggesting that many patients would find it difficult to access healthcare services including dentistry.

1.10 Somerset seems to be one of a few STP areas that have completed its National Epidemiology Dental Research in full, and thus efforts should continue to secure this important epidemiological data. The data for Somerset shows a lower level of 3-year-old dental decay (9.9%), when compared to national (11.7%) and regional (10.4%) findings. In Somerset, the data for 5-year-old dental decay is 17.5%, lower than nationally (23.4%) and the South West (20.4%). For 12-year-olds the level of dental decay in Somerset (37.4%) is higher than national (33.4%) and South West (33.3%) levels.

1.11 From a dental care service provision perspective, Somerset, in 2019-20 had 69 dental practices commissioned to carry our 860,662 UDAs[1]. This represented 326 dentists delivering NHS dentistry. Indeed, Somerset saw an increase of 4 dentists in 2019-20 to the year before, a 1.2% increase. The average UDAs per person was higher than the South West rate at 1.54 UDA/person as compared to 1.52 UDA/person.

1.12 In terms of access to dentistry the percentage of children that accessed NHS dentistry in the last 12 months[2] was 53% in Somerset, consistent with the South West (54%) percentage but below England (53%). The percentage of adults that accessed NHS dentistry in the last 24 months was 51% in Somerset, above the

[1] NHS Dental Services, NHS Business Services Authority (BSA).
[2] NHS Dental Services, NHS Business Services Authority (BSA).

South West level (47.3%) and above the national level (47.1%) although the differences are not significant.

1.13 Clawbacks from dentists that did not reach their UDA's targets in Bristol, North Somerset, Somerset and South Gloucestershire have been made in the last three years. Across the South West clawback was particularly high in 2018-19 with £5,604,177.

1.14 61% of treatment were Band 1, 25% Band 2, 4% Band 3 and 10% urgent treatment. This shows comparable levels of Band 1, 2 and 3 treatments and a higher level of urgent treatment when compared to national and regional levels. More urgent care tends to correlate to lower levels of regular routine dentistry. It may also reflect difficulty of access to NHS dentistry for some people. Further examination shows a higher proportion of non-paying adults (16%) than paying adults (11%) accessing urgent care.

1.15 Fluoride varnish application rates are higher than the rate in the South West with 56% of the child population. Oral cancers in Somerset stand at 13.0 per 100,000 – this is lower than the England (14.5 per 100,000) and South West (14.9 per 100,000) rates.

1.16 The key priorities emerging out of both Healthwatch Somerset and the patient and public surveys are summarised below. These provide commissioners with real insight into the priorities and concerns of patients in the area:

- Access to NHS dentists in your locality should be made easier
- Better dentist allocation
- NHS dentistry should be affordable
- Finding a private dentist is easy, there need to be more NHS dentists
- Improve the quality of care
- Increase capacity in all areas
- NHS dentistry should provide all services offered by private dentists
- Reduce waiting lists
- Urgent appointments should be easier to get for broken teeth and infections
- Work with young people to promote life-long good oral health.

Key priorities

1.17 The need for a **targeted increased of Child access to NHS dentistry** is an issue for key parts of Somerset. This is emphasised for a number of reasons:

1.17.1 NHS Digital data for 2019-2020 shows that access for children in Somerset was 53%, consistent with England (53%) but just below the South West (54%). However the percentage of adults that accessed NHS dentistry in Somerset (51%) was above the South West level (47.3%) and national level (47.1%).

1.17.2 The population of children under 18 is set to decline by 2028 by 1% on current levels. This suggests a slight decrease of need, however the issue of access to child dentistry remains critical and should be brought up to the South West level.

1.17.3 Somerset's rate of UDAs per person (1.54) was higher than the South West rate of UDA/person (1.52).

1.17.4 Additional NHS dentistry will need to be targeted to those areas of greatest deprivation and demand in the County. This is particularly necessary in Sedgemoor, Bridgewater, Taunton and Taunton Deane, parts of Yeovil and the coastal area north of Burnham-on-Sea.

1.17.5 Many residents engaged through the survey, focus groups and contact with HealthWatch, raised the difficulty people have had in being able to access an NHS dentist, often experiencing extensive waiting times and many dentists not opening their lists to any further patients.

1.18 There is a need to **support dental care services for older people** in the population. This is emphasised for a number of reasons.

1.18.1 There are proportionally more people of retirement age in the country (24%) compared to the South West (22%) and England (18%).

1.18.2 The 50 plus age groups within Somerset's population is proportionally larger for both male and females in the current baseline data for the area. (See chart 1 in section 2).

1.18.3 By 2028 the older adults (65+) population in Somerset will have grown by 24% (an additional 33,082 people).

1.18.4 The projected increase in the proportion of older adults may have result in increased demand for treatment.

1.19 There is a need to **support the recruitment and retention of dentist** working in NHS dentistry.

1.19.1 There are recruitment and retention concerns for dentists in rural and coastal areas.

1.19.2 Somerset saw a 1.2% increase in its dental workforce between 2018-19 and 2019-2020.

1.19.3 Joint action with local partners (LDN/LDC, HEE, local authorities) to facilitate recruitment of dentists and other members of the dental team in rural areas.

1.20 There is evidence that **dentists are experiencing difficulty in meeting their contractual targets.**

1.20.1 The increasing amounts of clawback - £4.4M in 2019-20[3].

1.20.2 There is are risks to future service provision because of the commercial viability of certain contracts.

1.20.3 GDS responding to the stakeholders surveys from Devon identified concerns regarding the GDS contract and the fulfilment of UDA targets.

1.21 There are a range of **other oral health priorities** that have emerged through this OHNA. Many of these will require support from key partners and in some cases they would be best served through partnership work. These include:

1.21.1 The area presents moderate prevalence of smoking, alcohol consumption and obesity. NHSE&I may wish to develop and strengthen the integration of dental services with a local authority commissioned oral health improvement programme in line with the Making Every Contact Count[4] (MECC) model.

1.21.2 Carers of adults with learning disabilities to be supported and given training in techniques to help support the oral health of those they care

[3] Figure relates to Somerset, North Somerset, Bristol and South Gloucestershire
[4] https://www.makingeverycontactcount.co.uk/

for. Most already understand the importance of this, but it can be challenging to get compliance from this patient group.

1.21.3 NHSE&I may wish to assess if there is adequate provision for domiciliary dental care considering Somerset's growth in older people.

1.21.4 The OHNA has highlighted the need to support residents in domiciliary care and to ensure that services providing for these people offer evidence-based interventions, training programmes for health, social care and domiciliary care staff[5].

1.21.5 Promoting early dental attendance and supporting programmes like Dental Check by One (DCb1)[6].

1.21.6 Investigate the lower levels of dental patent attendance - namely in the North East of the STP in Frome, north of Wells, and pockets around Bridgewater and Taunton.

1.21.7 Work to maintain the successful completion of national dental survey responses. Somerset is one of the only areas in the South West with a complete suite of current National Epidemiology survey results.

1.21.8 From an oral health improvement perspective there seems a need to continue to target resources to areas of higher deprivation that is prevalent across the county. These targeted interventions could include joint interventions with local authority partners such as:

- Supervised toothbrushing programmes for nurseries and primary schools in areas where children are at high risk of poor oral health.
- Provision of toothbrushes and tooth paste by health visitors and by post.
- Targeting of oral health programmes for key vulnerable groups in the community including the substance misusing population, those who are homeless, the traveler and gypsy community, older people, migrant communities and many who are deemed to be socially isolated.
- Developing the capacity of the oral health improvement workforce and that of health, social care and educational professionals.
- Reorientating dental care towards prevention.
- Encourage further multiagency working to develop and strengthen healthy eating policies in school and preschool settings.

[5] https://www.e-lfh.org.uk/
[6] https://dentalcheckbyone.co.uk/

2 Introduction

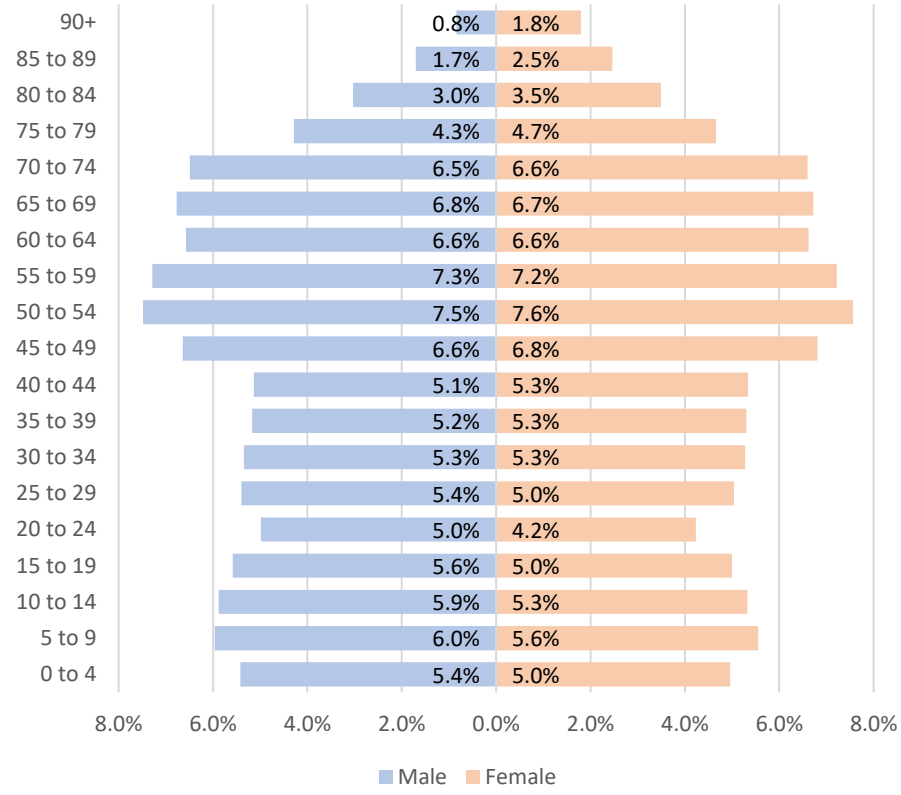
2.1 This section will set out the oral health needs and profile for Somerset. It will start with demographics, risks and determinants of poor oral health, relevant national epidemiology research findings, local oral health services, oral health improvement programmes and key findings relating to the oral health of the local population.

3 Demographics

Gender and Age

3.1 The population of Somerset is an estimated 559,399[7]. 30% of the total population of Somerset live in South Somerset. The population of Somerset consists of more females (51%) than males (49%) - this gender profile is consistent with the population of England. The age and gender profile of the population of Somerset is set out in the population pyramid below.

Chart 1: Gender and Age Somerset: ONS Mid -18 Estimates



3.2 58% of the population of Somerset are of working age, (16 to 64 years), 24% are of retirement age (65 years and over) and 18% are children and young people (aged under 16 years). Compared with England as a whole, there are less people of working age and more people of retirement age and the proportion of children and

[7] ONS mid-2018 estimates

young people is the same. This age profile is broadly consistent at local authority level as set out in the table below.

Table 1: Age Somerset: ONS Mid -18 Estimates

	Children and young people (under 16 years)		Working-age population (16-64 years)		Retirement age population (65 years and older)		Total population
	(n)	(%)	(n)	(%)	(n)	(%)	(n)
Somerset West and Taunton	26370	17%	88298	57%	39198	25%	153866
Sedgemoor	22105	18%	71781	58%	28905	24%	122791
South Somerset	29525	18%	96056	57%	42280	25%	167861
Mendip	20750	18%	67653	59%	26478	23%	114881
South West	986908	18%	3382627	60%	1230200	22%	5599735
Somerset	98750	18%	323788	58%	136861	24%	559399
England		18%		64%		18%	

Population projections

3.3 A review of the subnational population project for England (2018)[8] indicates the potential future populations for English local and health authorities. The data below for Somerset has been taken from the CCG dataset. This data has been broken down by total population shift, shifts in the child (0-15) population and shifts to the older population (65+). It is defined by total counts, the additional numbers of people in each category and the level of growth based on a percentage (%) against the 2018 figure.

Table 2: NHS Somerset CCG Population Projections 2018-2043

Population growth	2018	2023	2028	2033	2038	2043
Total Population shift	559399	579491	596392	610393	623181	635316
Additional people		20092	36993	50994	63782	75917
% Growth		4%	7%	9%	11%	14%
0 to 15 population shift	98750	100249	97340	94717	95392	97771
Additional Young people		1499	-1410	-4033	-3358	-979
% Growth		2%	-1%	-4%	-3%	-1%
65+ population shift	136861	151780	169943	189249	203102	208065
Additional older People		14919	33082	52388	66241	71204
% Growth		11%	24%	38%	48%	52%

3.4 What is evident from this analysis is that by 2028 the total population of Somerset will have grown by 7% (an additional 36,993 people). Within this, the child population will have only declined by -1% (-1,,410) and the older adult (65+)

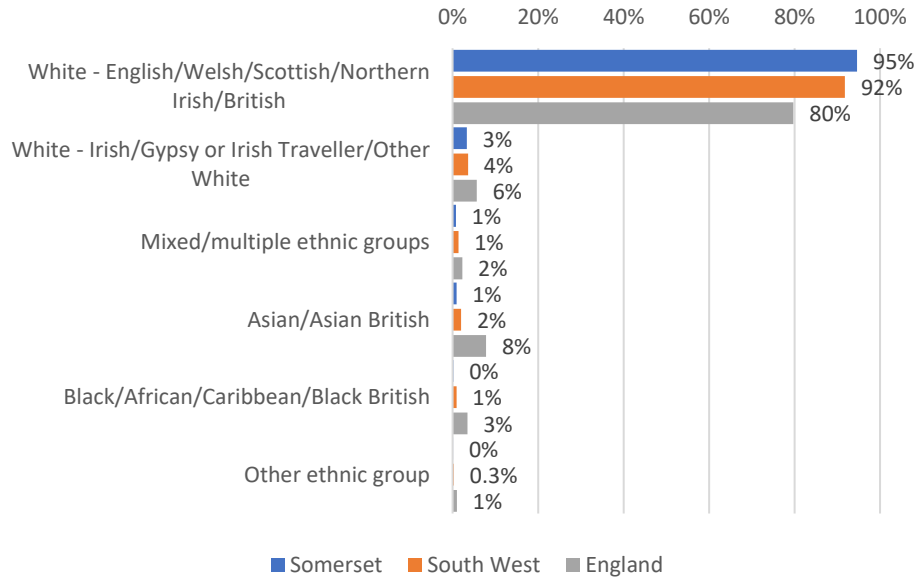
[8] Subnational population Projections for England 2018 https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2018based

population will have grown by 24% (an additional 33,082 people). This demographic change may inform the planning of dental services around the increase of older people's dental needs. The shift in the child population suggests that there will be marginally less child patients, therefore this is unlikely to impact on the oral health needs of children in the county.

Ethnicity

3.5 There is less ethnic diversity in the population of Somerset compared to England and the South West. 2% of the population are from BAME groups whilst across England this group represents 20% and across the South West it is 5%.

Chart 2: Ethnicity Profile Somerset ONS 2011



3.6 There are some variations in the ethnic profile at local authority area level – the highest BAME population is in Taunton Deane (7%) whilst West Somerset has the lowest proportion of people from BAME groups at 4%.

Table 3: Ethnicity Profile Somerset ONS 2011

	White - English/ Welsh/ Scottish/ Northern Irish/ British	White – Irish/ Gypsy or Irish Traveller/ Other White	Mixed/ multiple ethnic groups	Asian/ Asian British	Black/ African/ Caribbean/ Black British	Other ethnic group	BME (total)	BAME (total)
West Somerset	96%	3%	1%	1%	0.1%	0.1%	4%	1%
Taunton Deane	93%	4%	1%	1%	0.3%	0.2%	7%	3%
Sedgemoor	95%	3%	1%	1%	0.1%	0.1%	5%	2%
South Somerset	95%	3%	1%	1%	0.2%	0.1%	5%	2%
Mendip	94%	4%	1%	1%	0.2%	0.1%	6%	2%
Somerset	95%	3%	1%	1%	0.2%	0.1%	5%	2%
South West	92%	4%	1%	2%	1%	0.3%	8%	5%
England	80%	6%	2%	8%	3%	1%	20%	15%

Deprivation

3.7 In terms of overall levels of deprivation[9] Somerset generally comes out better than the national average. Since 2015 there has been a slight shift towards greater deprivation in Somerset relative to the rest of England, particularly in relation to the quality of housing. The number of 'highly deprived' neighbourhoods in Somerset (categorised as being within the 20% most deprived in England) increased to 29 in IMD 2019, up from 25 at the time of IMD 2015.

3.8 Around 47,000 Somerset residents now live in a neighbourhood (LSOA) identified as one of the 20% most deprived in England.

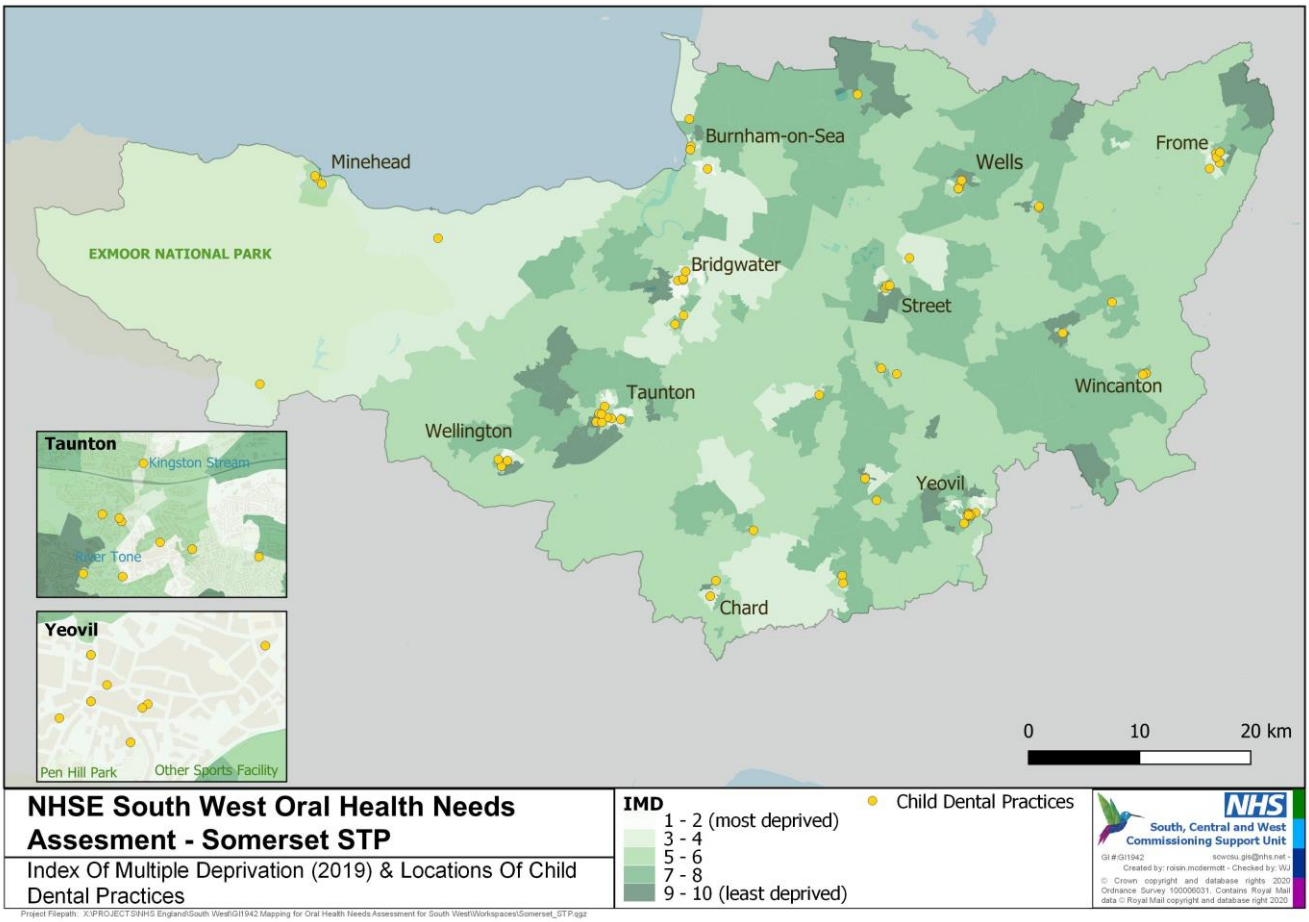
- The highest levels of deprivation are found within the County's larger urban areas. The most deprived area of Somerset is the Highbridge South West area of Sedgemoor.
- The least deprived area is in the Sampson's Wood area of Yeovil, which falls within the 1% least deprived in England.
- Children in Somerset face greater income deprivation than older people.

3.9 The map below describe the index of Multiple Deprivation (2019) and marks the location of Dental Practices that provide for children.

9 http://www.somersetintelligence.org.uk/files/English%20Indices%20of%20Deprivation%202019%20-%20Somerset%20summary.pdf

Map 1: Somerset IMD 2019 Child Dental practices[10]

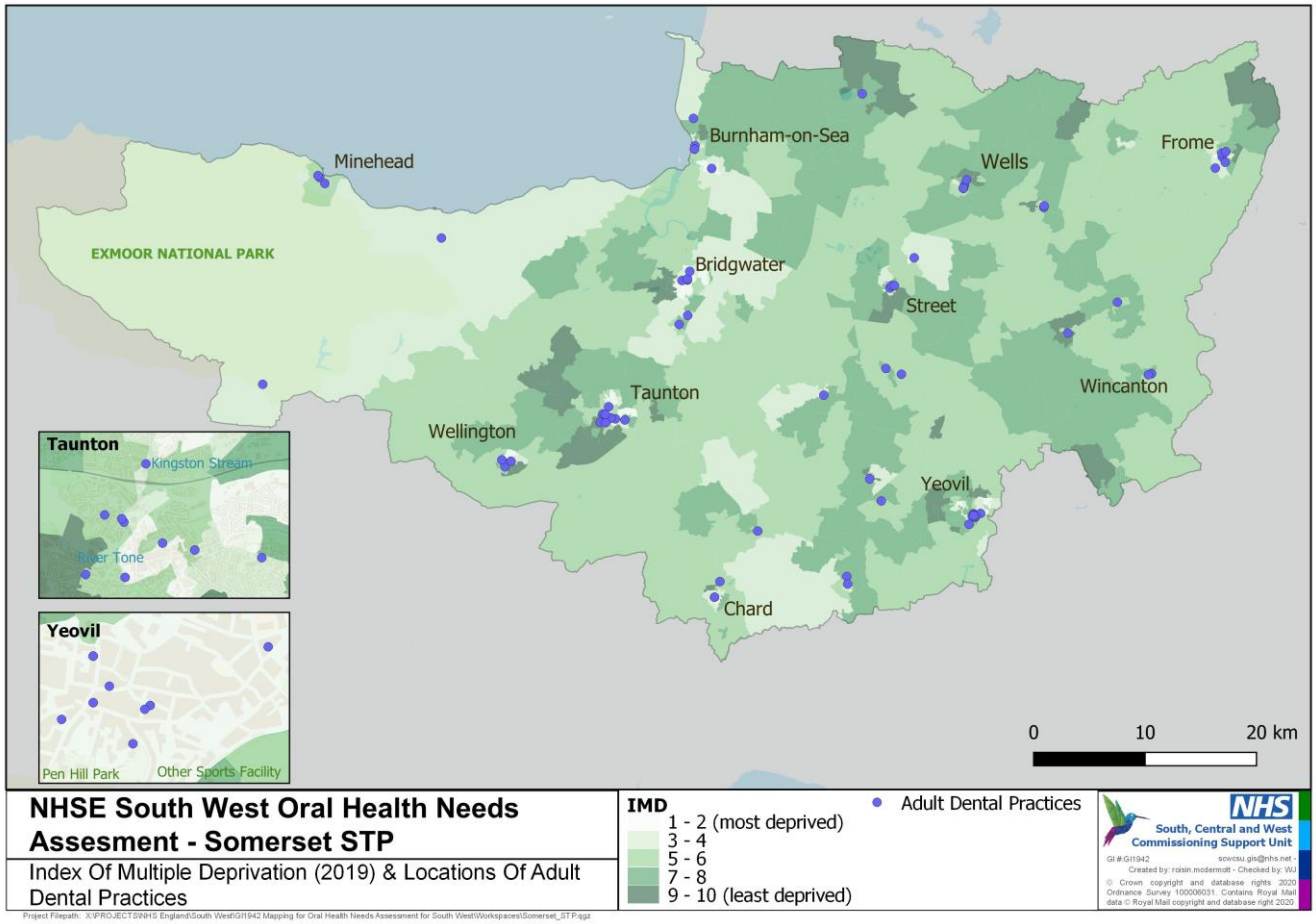
3.10 The locations of child dental practices are broadly clustered around urban areas.



This meets some of the demand in Band 1-2 and 3-4 IMD areas which tend to be clustered around urban areas.

[10] NHS South, Central and West Commissioning Support Unit Oct 2020

Map 2: Somerset IMD Adult Dental Practices[11]



3.11 The locations of adult dental practices are broadly clustered around urban areas. This meets some of the demand in Band 1-2 and 3-4 IMD areas which tend to be clustered around urban areas.

3.12 These maps suggest that there are certain deprived areas requiring additional provision of dental services.

4 Risks and determinants of poor oral health

4.1 Healthy behaviours can contribute to the prevention and control of non-communicable diseases such as cardiovascular diseases, chronic respiratory diseases, diabetes and cancers. PHE Fingertips and NHS Digital monitor trends in the nation's health and health related behaviours. It is important to consider these factors as certain chronic conditions share common risk factors with oral disease. Furthermore, the age profile of the region suggests a potential increase of the

[11] NHS South, Central and West Commissioning Support Unit Oct 2020

prevalence of chronic conditions which may have implications for the planning of dental services.

4.2 The under 75 mortality rate, per 100,000 from all cardiovascular disease in England in 2016-2018 was 71.7, the South West rate was lower at 61.9 and in Somerset was lower still, at 56.2. The adult populations diabetes prevalence profile (QoF 2018-19) for England was 6.93%, for the South West it was 6.65% and for Somerset it was 7.07%. The under 75 mortality rates, per 100,000 from a respiratory disease considered preventable in 2016-2018 was 19.2 per 100,000 in England, 15.6 in the South West, and 14.7 in Somerset. The proportion of deaths in a person's usual place of residence (DiPUPR) from a respiratory disease in 2016 was 32.17% in England, 38.25% in the South West and 36.01% in Somerset. This data is set out in the table below:

Table 4: Health indicators, Cardiovascular disease, Diabetes prevalence and Respiratory disease, national, regional and local

Indicator	England	South West region	Somerset
Under 75 mortality rate per 100,000 from all cardiovascular diseases[12]	71.7	61.9	56.2
Diabetes: QOF prevalence (17+) (%)[13]	6.93	6.65	7.07
Under 75 mortality rate per 100,000 from respiratory disease considered preventable (Whole Pop)[14]	19.2	15.6	14.7
DiPUPR - Respiratory disease (%), Persons, All Ages.[15]	32.17	38.25	36.01

4.3 The key health behaviours reviewed in this OHNA have been healthy eating, physical activity levels (adults), obesity (child and adult), alcohol misuse and smoking prevalence. These lifestyle factors are pertinent to general health and wellbeing as well as oral health.

Healthy Eating

4.4 A healthy and balanced diet is critical to preventing ill health and disease. The annual cost of food related ill health to the NHS is estimated at £5.8 Billion[16]. A minimum intake of five portions of fruit and vegetables is an important component of a healthy diet and is the measure used for healthy eating. The proportion of the population aged 15 that eat 5 portions of fruit and vegetables is 52.4% in England - higher at 56.5% in the South West and slightly lower in Somerset with 55.6%. The

[12] PHE: Public Health Profiles: Fingertips 2016-18
[13] PHE: Public Health Profiles: Fingertips 2018-19
[14] PHE: Public Health Profiles: Fingertips 2016-18
[15] PHE: Public Health Profiles: Fingertips 2016
16 The Burden of Food Related Ill Health in the UK; Epidemiology in Community Health Dec 20

proportion of the adult population meeting the recommended 5-a-day on a usual day was 54.61%, although this was greater in the South West at 59.55% and higher again in Somerset at 60.71%.

Table 5: Healthy Eating indicators 5-a-day 15 year olds and adults national, regional and local

Indicator	England	South West region	Somerset
Percentage who eat 5 portions or more of fruit and veg per day at age 15[17]	52.4	56.5	55.6
Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)[18]	54.61	59.55	60.71

Physical activity levels (adults)

4.5 Lack of physical activity is an important risk factor for chronic non-communicable diseases such as ischemic heart disease and stroke with an estimated direct cost to the NHS of £1.1 billion and overall cost to the country of £7.4 Billion[19]. Guidelines for physical activity suggest adults (aged 16 and over) should have 150 minutes of activity of moderate intensity each week. The Active Lives Survey[20] commissioned by Sport England and the PHE Physical Activity survey data[21] differ slightly in the definition of activity and what this includes. PHE include non-recreational exercise i.e. gardening within their assessment of activity. The data shows that the South West region has a slightly higher level of active residents with 67.4% as compared to England with 63.6% and Somerset with 65.4%. Correspondingly the level of inactive residents is 20.8% in the South West as compared to 24.6% for England and Somerset at 23.3%.

Table 6: Physical activity levels national, regional and local

Indicator	England	South West region	Somerset
Active (150+ minutes a week)	63.6	67.4	65.4
Fairly Active (30-149 minutes a week)	12.2	11.8	11.4
Inactive (<30 minutes per week)	24.6	20.8	23.3
% Active (150+ mins a week)	57	59.2	58.8
% Some activity (90-149 mins a week)	6.9	7.1	5.9
% Low activity (30-89 mins a week)	7.4	7.3	8.2
% Inactive (<30 mins)	28.7	26.3	27.1

[17] PHE: Public Health Profiles: Fingertips 2014-15
[18] PHE: Public Health Profiles: Fingertips 2018-19
[19] PHE: Everybody active everyday Oct 2014
[20] Sport and physical activity levels Adults aged 16+ Nov 18 – Nov 18 % published Sport England Active Lives 23rd April 2020
[21] PHE: Physical activity levels among adults in England, 2015

Obesity (Child and Adult)

4.6 Whilst not a health-related behaviour, being overweight or obese is generally associated with unhealthy diet and lack of physical activity. Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health. Obesity in adults is associated with cardiovascular diseases, diabetes, musculoskeletal disorders and some cancers. It is estimated that the NHS spent £6.1 billion on overweight and obesity-related ill-health in 2014 to 2015[22].

4.7 The annual child weight measurement programme is completed locally and is fed into the national database held by PHE. The data set out below is taken from PHE Fingertips data for 2018-19.

4.8 South West and Somerset profiles for Reception and Year 6 prevalence of overweight including obesity are slightly below the England prevalence. The prevalence of obesity amongst the South West and Somerset profiles for Reception are also below the England prevalence. The South West adult percentage of those classified as overweight and obese is 61.35% compared to England at 62.34%.

Table 7: Overweight and Obesity levels children and adults national, regional and local

Indicator[23]	England	South West region	Somerset
Reception: Prevalence of overweight (including obesity) (%)	22.59	22.05	22.31
Year 6: Prevalence of overweight (including obesity) (%)	34.29	29.88	31.54
Reception: Prevalence of obesity (including severe obesity) (%)	9.68	8.74	8.62
Year 6: Prevalence of obesity (including severe obesity) (%)	20.22	16.52	17.94
Percentage of adults (aged 18+) classified as overweight or obese (%)	62.34	61.35	65.81

Alcohol misuse

4.9 Alcohol use can affect health and increases the risks of accidents, injury, and violence. The health harms of alcohol are dose dependent; that is, the risk increases with the amount drunk.

4.10 To avoid the risk of alcohol-related harm, the recommended limits are no more than 21 units per week in men and 14 units per week in women. Adults who regularly drink more than these amounts are at increased risk. Men and women who regularly drink more than 8 units a day (or 50 units a week) and more than 6 units a day (or 35 units a week) and more, respectively, are higher risk drinkers and are exposed to greater harm. The proportion of adults over the age of 16 years who are higher risk drinkers is described below with the South West at3.21%, lower compared to England at 4.04%. Somerset has a lower than national level of

[22] Health matters obesity and the food environment PHE March 2017.
[23] PHE: Public Health Profiles: Fingertips 2018-19

admissions for alcohol specific conditions. However, it has slightly higher alcohol related mortality rate.

Table 8: Alcohol hospital admissions, mortality rates and consumption rates national, regional and local

Indicator	England	South West region	Somerset
Admission episodes per 100,000 for alcohol-specific conditions[24]	869.25	814.97	816.27
Alcohol-related mortality per 100,000[25]	46.54	45.55	47.37
Admission episodes for alcohol-related conditions (Broad) per 100,000[26]	2367.40	2142.39	2296.90
Estimated weekly alcohol consumption, by region: More than 14, up to 35/50 units (increasing risk) Age Standardised %[27]	18.18	19.56	Data not available
Estimated weekly alcohol consumption, by region: More than 35/50 units (higher risk) Age Standardised %[28]	4.04	3.21	Data not available

Smoking prevalence

4.11 Tobacco use is a risk for cancers and chronic respiratory and circulatory disease[29]. In England tobacco smoking is the greatest cause of preventable illness and premature death.

4.12 The 2009 Adult Dental Health Survey reported that more men than women smoked, and that smoking was socially patterned, with 8.8% of participants smoking in the least deprived areas compared to 26.4% in the most deprived. The 2018 Health Survey for England showed that 10% of current smokers lived in the least deprived areas whereas 28% of smokers lived in the most deprived areas. This suggests that smoking prevalence is more concentrated in with deprived areas.

4.13 The indicators for smoking prevalence show a level of variability from survey to survey. In England just under 10.6% of women were smokers at the time of delivery - this was higher at 10.9% in the South West and higher still in Somerset with 11.73%. The prevalence of adult smokers (QoF) in 2018 showed that 17.2% of the England population were smokers, compared to 16.5% in the South West and 17.4% in Somerset. The GP Survey in 2018-19 showed that 14.5% of over 18-year olds were smokers compared to 13.7% in the South West and 14.2% in Somerset.

[24] PHE: Public Health Profiles: Fingertips 2018-19
[25] PHE: Public Health Profiles: Fingertips 2018
[26] PHE: Public Health Profiles: Fingertips 2018-19
[27] Health Survey for England 2018
[28] Health Survey for England 2018
[29] WHO

Table 9: Smoking prevalence rates national, regional and local

Indicator	England	South West region	Somerset
Smoking status at time of delivery (%)[30]	10.59	10.91	11.73
Estimated smoking prevalence (16+) (QOF)[31]	17.19	16.50	17.44
Smoking prevalence in adults (18+) - current smokers (GPPS)[32]	14.46	13.75	14.17

Oral hygiene practices

The most prevalent oral diseases - tooth decay and gum diseases can both be reduced by regular tooth brushing with fluoride toothpaste. When brushing teeth, the fluoride in toothpaste is the key ingredient to control tooth decay, as it prevents, controls and arrests decay. Higher concentrations of fluoride in toothpaste lead to better control. By contrast, the physical removal of plaque is the important element of tooth brushing to control gum diseases as it reduces the inflammatory response of the gum and its consequences. In 2008/09, most 12-year-old schoolchildren in the South West reported brushing their teeth twice daily (73%) compared to 73% in England.

5 Transport and Communications in Somerset

5.1 There are many people across the country who are not able to access important local services and activities such as jobs, learning, healthcare, food shopping or leisure due to a lack of adequate transport provision[33]. The University of Leeds report demonstrates that mobility and accessibility inequalities are highly correlated with social disadvantage. This means that some social groups are more at risk from mobility and accessibility inequalities than others:

- Car owners are least mobility constrained across all social groups.
- Lowest income households have higher levels of non-car ownership, 40% still have no car access – female heads of house, children, young and older people, black and minority ethnic (BME) and disabled people are concentrated in this quintile.
- In addition, there are considerable affordability issues with car ownership for many low-income households.

[30] PHE: Public Health Profiles: Fingertips 2018-19
[31] PHE: Public Health Profiles: Fingertips 2018
[32] PHE: Public Health Profiles: Fingertips 2018-19
[33] Inequalities in Mobility and Access in the UK Transport Social and Political Science Group, Institute for Transport Studies, University of Leeds March 2019 Systemhttps://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784685/future_of_mobility_access.pdf

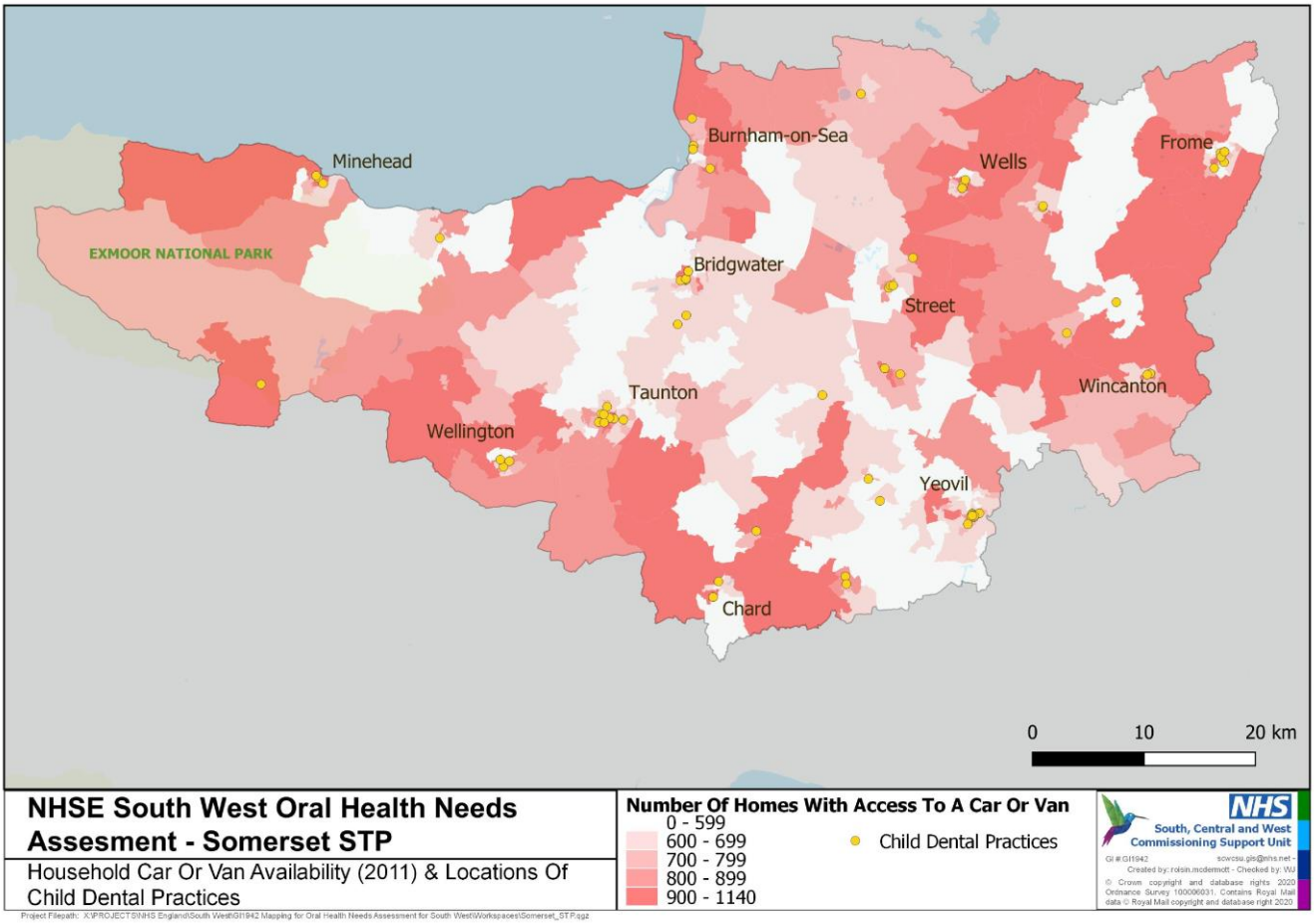
5.2 Inequalities in the provision of transport services are strongly linked with residential location, this is further exemplified in rural and coastal communities. However, the lack of private vehicles in low-income households, combined with limited public transport services in many peripheral social housing estates, considerably exacerbates the problem in many parts of the UK.

5.3 In 2003 the Social Exclusion Unit report 'Making the Connections[34]' identified that two out of five job seekers could not get a job due to a lack of transport, 31% of people without cars could not access a hospital, 16% of households without cars found it difficult to access a supermarket, and 6% of 16- to 18-year-olds turned down training or further education because of travel costs.

5.4 The resent public and patient survey has shown that 90% of respondents travelled to their local dentist by car, 10% by walking/bicycle and there were no respondents that stated they took public transport. To support this OHNA we have worked with the NHSE South West Commissioning Support Unit to identify the level to which people across the area have access to a car or a van. This has been overlayed with the location of dental practices which provide for both children and adults.

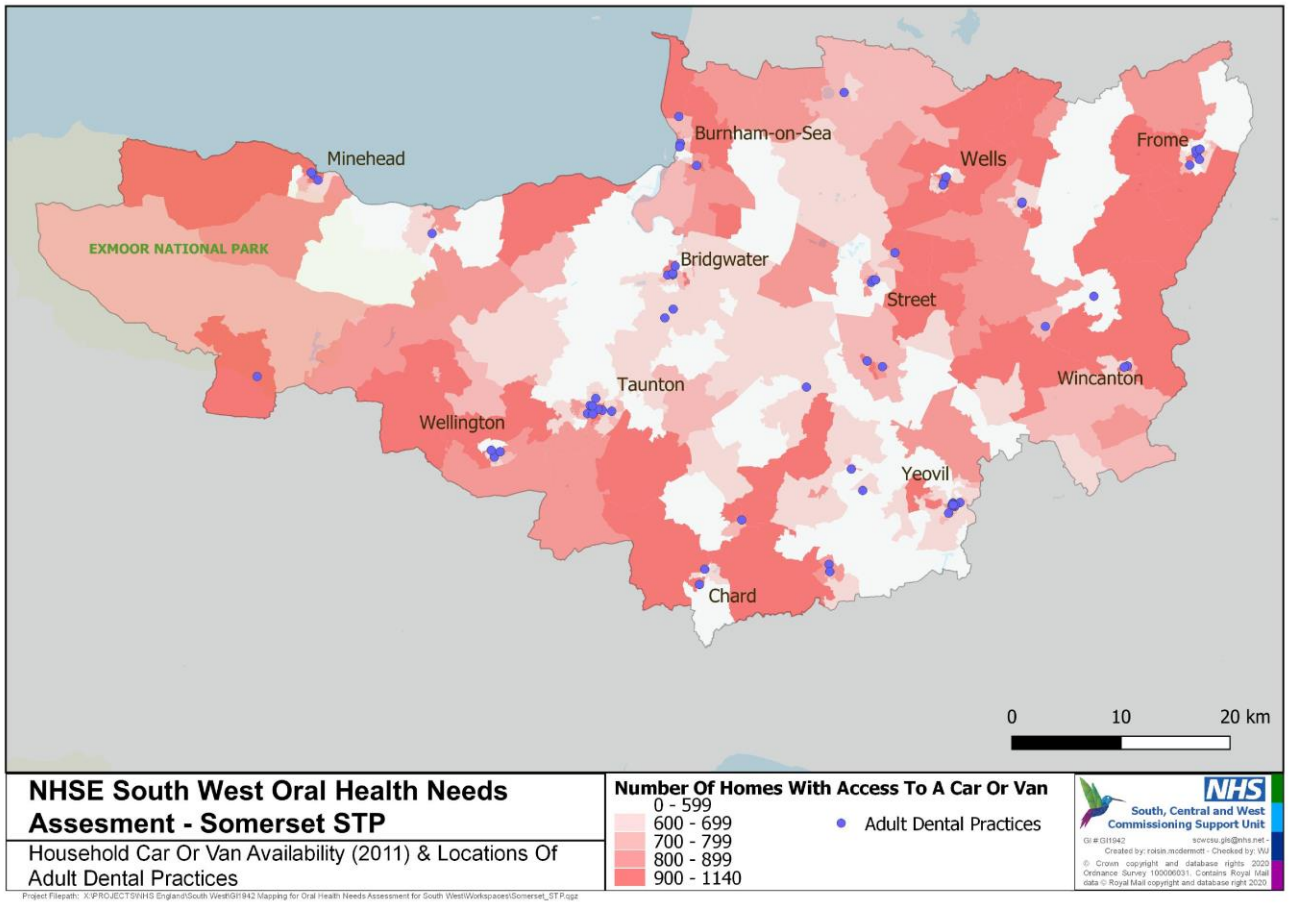
[34] Social Exclusion Unit 2003 Making the Connections. http://www.ilo.org/wcmsp5/groups/public/---ed_emp/---emp_policy/---invest/documents/publication/wcms_asist_8210.pdf

Map 3: Household Car or Van availability (2011) by LSOA and locations of Child Dental Practices[35]



[35] NHS South Central and West Commissioning Support Unit Oct 2020

Map 4: Household Car or Van availability (2011) by LSOA and locations of Adult Dental Practices[36]



5.5 These maps show that there are key areas across the county where car ownership is lower. By correlating this to existing dental provision we can identify those areas where there is priority for investment both due to inaccessibility or low car ownership and as a result of the lack of high street dentistry.

[36] NHS South Central and West Commissioning Support Unit Oct 2020

6 National Dental Epidemiology Research Findings

6.1 The table below sets out the headline findings for Somerset from the National Dental Epidemiology programme research undertaken for 3-year0olds (2013), 5-year-olds (2019), 12-year-olds (2008-09) and Adults in Practice (2018). It sets out comparators for England and the South West.

Table 10: NDEP Headline results for Somerset

3-year-old 2013	England	South West region	Somerset
3-year-old % tooth decay (% d3mft > 0 including incisors)	11.7	10.4	9.9
3-year-old Number of teeth with decay experience (Mean d3mft including incisors)	0.36	0.31	0.33
5-year-olds 2019	**England**	**South West region**	**Somerset**
5-year-old % tooth decay (% d3mft > 0 including incisors)	23.4	20.4	17.5
5-Year-old Number of teeth with decay experience (Mean d3mft including incisors)	0.8	0.6	0.6
5-Year-old Number of teeth with decay experience (Mean d3mft including incisors) 2017	0.80	0.60	0.6
Care Index % (ft/d3mft)	10.3	10.9	8.5
12-year-olds 2008-09	**England**	**South West region**	**Somerset**
12-year-old % tooth decay (% d3mft > 0 including incisors)	33.4%	33.3%	37.4%
12-year-old Number of teeth with decay experience (Mean d3mft including incisors)	0.74	0.73	0.86
12-year-old Care Index % (ft/d3mft)	47%	47%	51.8%
Adults in Practice 2019	**England**	**South West region**	**Somerset**
Adult in Practice % with a functional dentition	81.9	82.2	81.2
Adult in Practice % with active decay (DT>0)	26.8	31.5	46.0
Adult in Practice Average number of decayed teeth (for those with active decay)	2.1	1.9	2.4
Adult in Practice % with filled teeth	90.2	90.8	94.6
Adult in Practice % with dentures	15.4	14.4	15.3
Adult in Practice % with bleeding on probing	52.9	69.2	84.1
Adult in Practice % with PUFA	5.2	6.5	6.6
Adult in Practice % with any treatment need	70.5	81.9	94.0
Adult in Practice % with an urgent treatment need	4.9	8.2	15.2

7 Oral Health Services

7.1 The current primary care NHS dental contracts, the General Dental Service Contract and Personal Dental Service Agreement, were introduced in 2006. The contractual currency for both contracts is the Unit of Dental Activity (UDA). A general dental service provider is contracted for an annual agreed number of units of dental activity.

7.2 Dental practices provide services according to four different bands of care with the provider awarded different numbers of UDAs for each band:

Band 1 includes an examination, diagnosis and advice. If necessary, it also includes, x-rays, scale and polish, application of fluoride varnish or fissure sealants and preventive advice and planning for further treatment (1 UDA).

Band 2 includes all treatment covered by Band 1, plus additional treatment, such as fillings, root canal treatment, gum treatments and removal of teeth (3 UDAs).

Band 3 includes all treatment covered by Bands 1 and 2, plus more complex procedures, such as crowns, dentures and bridges (12 UDAs).

Band 4 urgent includes urgent care such as removal of the tooth pulp, removal of up to two teeth, dressing of a tooth and one permanent tooth filling (1.2 UDAs).

7.3 Fee paying adults contribute towards the costs of NHS dental treatment with the contribution determined by the band (the patient contribution is the same for Band 1 and Band 1 urgent).

Availability of general dental services

7.4 In 2019/2020, 705 dental practices across the South West were contracted by the NHS to provide a total of 8,520,528 UDAs. The number of dental practices, contracted activity and delivered activity is shown in the table below. For Somerset there were 69 practices commissioned to deliver, between them, 860,662 UDAs. The amount dentists were paid per UDA varied considerably from £19.89 to £33.16.

Table 11: Primary Care General Dental Services Provision across the South West

Sustainable Transformation Partnership (STP)	Contracts GDS and Ortho	General Dental Services/Mixed GDS and Ortho	Number of Practices	Commissioned UDAs	Average UDA Value	Ortho Only
Somerset STP	64	62	69	860,662	£25.38 (Lowest £19.89 to highest £33.16)	8
Total	748	681	705	8,520,528	-	53

Numbers of Dentists[37]

7.5 In 2019/2020 there were 2,664 dentists in the South West delivering NHS dentistry. This represented 48 dentists per 100,000 of the population which is slightly higher than the national average of 44. This was a slight increase, of 8 dentists regionally which represented a 0.3% growth in dentists when compared to the 2018-2019 period. In Somerset this was 326 dentists delivering NHS dentistry.

7.6 The average across the South West is 48/100,000, higher than in England at 44/100,000, in Somerset this is 58/100,000. The population per dentist in England is 2,268 which is higher than the population per dentist in the South West of 2,104, and in Somerset it is 1,716. In 2019/2020 Somerset saw an increase of 4 dentists (1.2%).

Table 12: Number of dentists with NHS activity, for years ending 31 March, England - NHS England region geography and CCG[38]

			2019/20		
Area	Dentists difference 2018/19 to 2019/20	Percentage difference 2018/19 to 2019/20	Total dentists	Population per dentist[2]	Dentists per 100,000 population[2]
England	**139**	***0.6***	**24,684**	**2,268**	**44**
South West of England	**8**	***0.3***	**2,664**	**2,104**	**48**
NHS Somerset CCG	**4**	***1.2***	326	1,716	58

Average UDAs commissioned per person.

7.7 Based on the numbers of commissioned UDA and comparing this to the general population in each locality across the South West it is possible to assess the average UDAs commissioned per person in the region. This shows a potential disparity in the proportionality of commissioned UDA by the local population sizes in each STP area.

7.8 What is clear is that there are higher levels per head of commissioned UDAs in Somerset compared to the South West average.

Table 13: Average UDAs commissioned per head of population.

Area	Average UDAs commissioned per person (n)
Somerset	1.54
Average for South West	1.52

[37] NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2019-20-annual-report
[38] NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2019-20-annual-report

Access to Dental Care

Children

7.9 Most children and adults will seek care from an NHS dental practice, with those with additional needs generally being seen in community dental services. According to NICE guidance, adults should be seen for a dental recall at intervals from 3 to 24 months and children should be seen at intervals from 3 to 12 months depending on their oral disease[39] risk level. Dental attendance does not necessarily prevent dental disease, but it is important in terms of assessing patient risk to oral diseases and giving appropriate evidence-based advice. Public Health England and NICE have developed specific guidance for dental teams. The indicator used to assess dental access in children is the number of separate people accessing dental services over the previous 12 months.

7.10 From April 2019 to March 2020 access for child patients in the South West was 54.1%, a higher level than the England average of 52.7%. In Somerset, the access level for child patients was 53.4% of the child population, which is below the South West average but above the England average[40].

Adults

7.11 The indicator used to assess dental access in adults is the number of unique people accessing dental services over the previous 24 months. This metric is based upon NICE guidance, which recommends the longest interval between dental recalls[41]. From April 2019 to March 2020 access for adult patients in the South West overall had fallen by 1.51% to 47.3%. Access levels are slightly below the England average of 47.7% In Somerset the access levels for adults was 50.7% above both the South West and England percentages. (Source: NHS Dental Services: NHS Business Services Authority: June 2020).

Table 14: Adult patients seen in the previous 24 months and child patients seen, in the previous 12 months as a percentage of the population, by patient type and LA[42]

Area	Adult % of pop.	Child % of pop
England	47.1	52.7
South West	47.3	54.1
Somerset County Council	50.7	53.4

7.12 The map below sets out the activity of dental practices based on the count of patients seen, in the case of adults within the last 24 months and in the case of

[39] The National Institute for Health and Care Excellence. Dental checks: intervals between oral health reviews: Clinical guideline [CG19] 2004 [Available from: https://www.nice.org.uk/guidance/cg19]

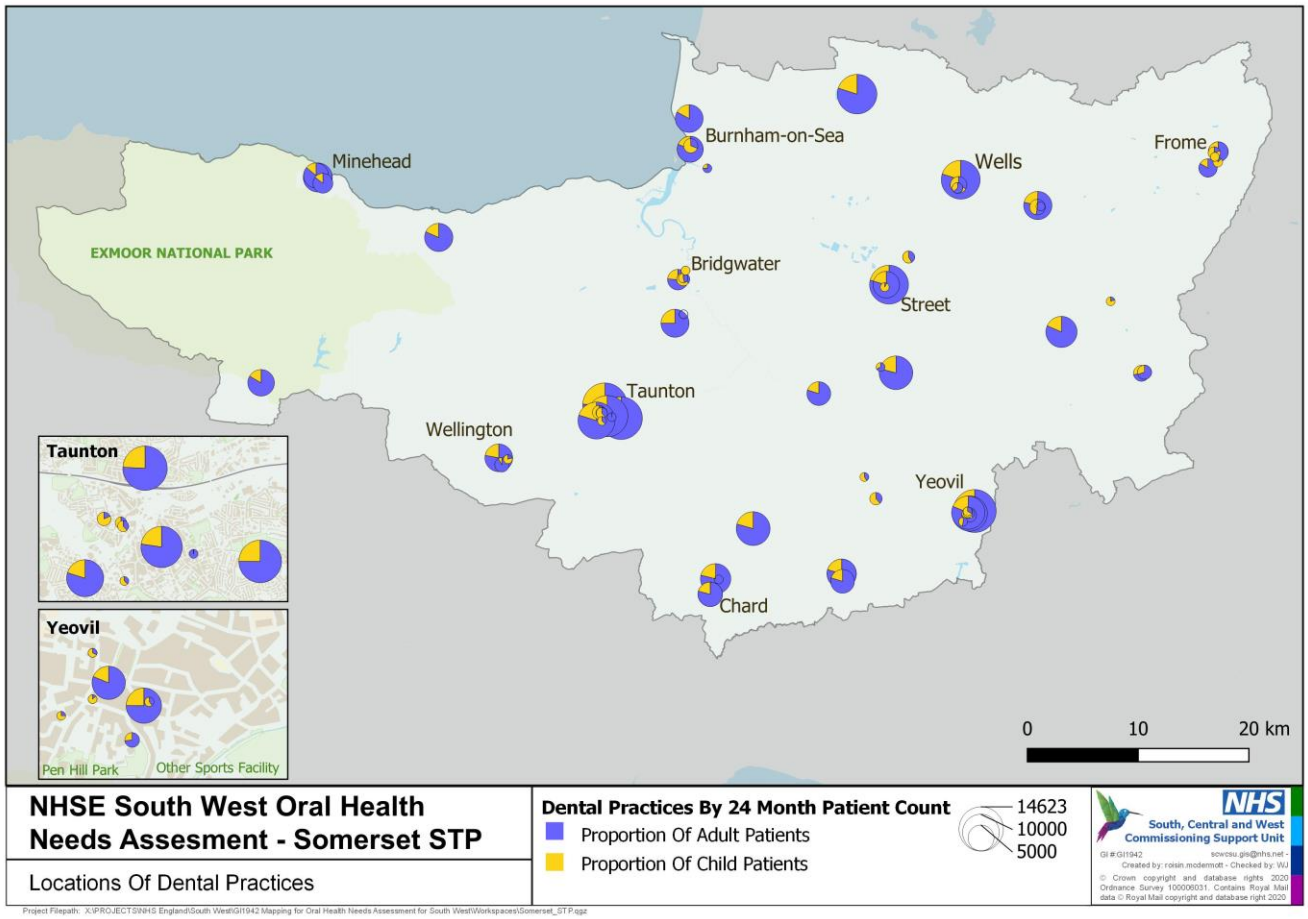
[40] NHS Dental Services: NHS Business Services Authority: June 2020.

[41] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215663/dh_126005.pdf

[42] NHS Dental Services, NHS Business Services Authority (BSA).

children in the last 12 months, as per the guidelines used by NHS Digital. What the map describes is the location of the practices across the region and the pie charts show the split and size of practice as per the legend.

Map 5: Local of Dental Practices by proportion of Adult and Child Patients[43]

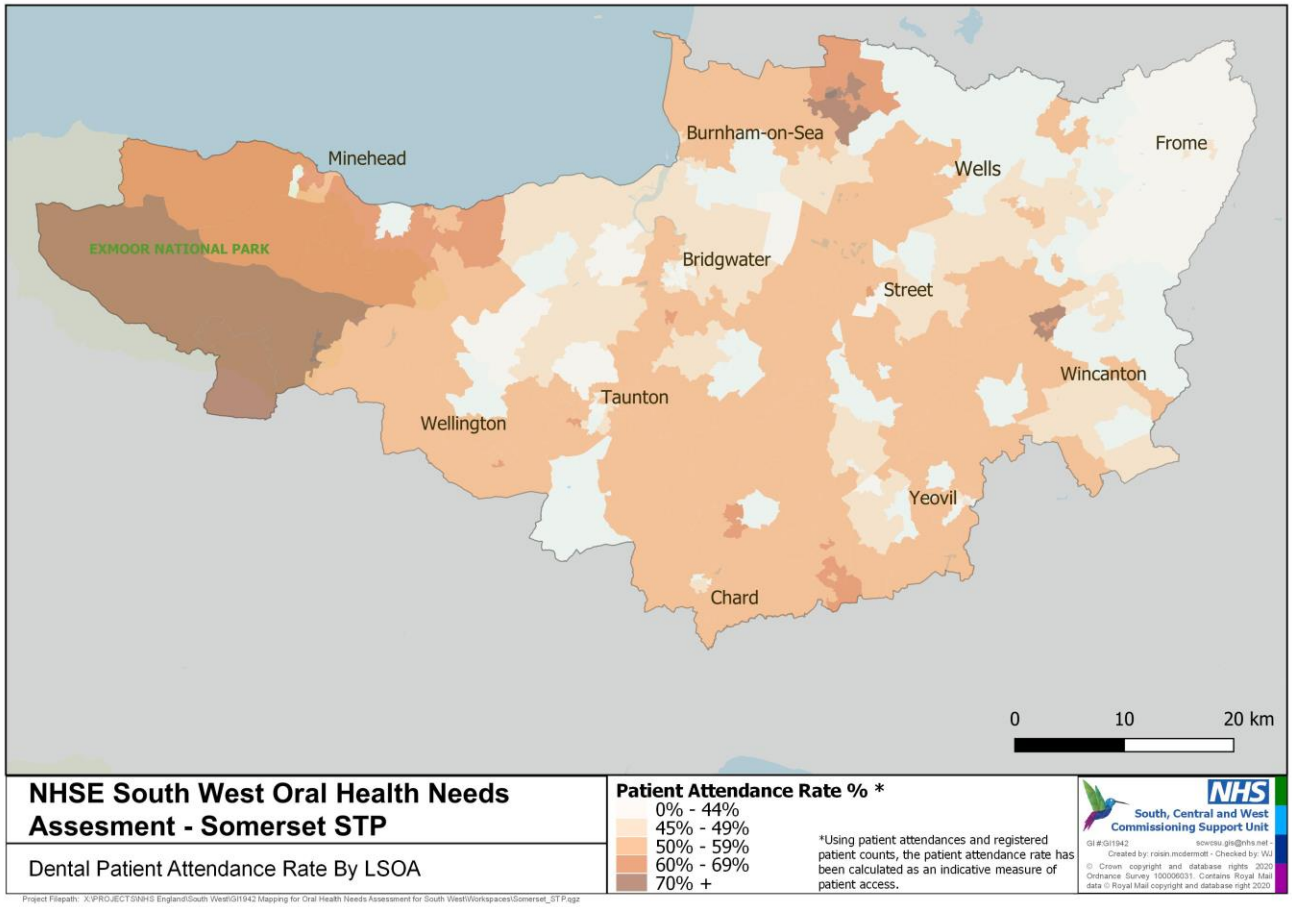


7.13 There were considerable concerns raised in the patient and public survey regarding great difficulty to access NHS dentistry in the county. Practices that see NHS patients are presented in this map. A key issue is the geographical spread of the practices, which inevitably seem to be linked to the major towns across the county. Moreover, there is no indication as to whether these practices are taking on new patients.

7.14 The map below sets out the patient attendance rate as a percentage of the local population. Most of the county is based on a 50-59% attendance rate but there are several localities where this is significantly lower. This is particularly the case in the North East of the STP in Frome, north of Wells, and pockets around Bridgewater and Taunton.

[43] NHS South, Central and West Commissioning Support Unit Oct 2020

Map 6: Dental Patient Attendance Rate by LSOA (%)[44]



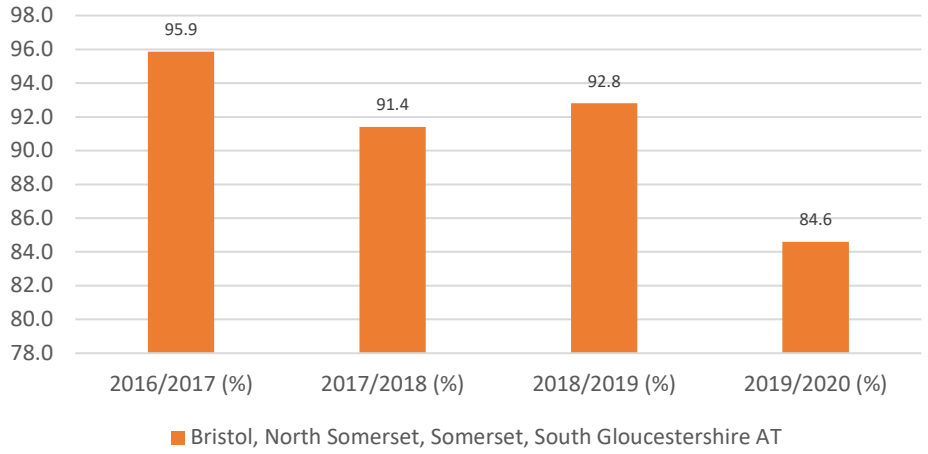
UDA/Contract performance

7.15 In England in 2015/2016, £54,505,326 was clawed back from practices, who did not meet their contractual targets, this increased to £81,506,678 in 2016/2017, £88,774,248 in 2017/2018 and £138,438,340 in 2018/2019.

7.16 The chart below presents achievement against target of dentistry funded through the UDA contracting system for Somerset. The chart below shows the % of UDAs achieved against their target.

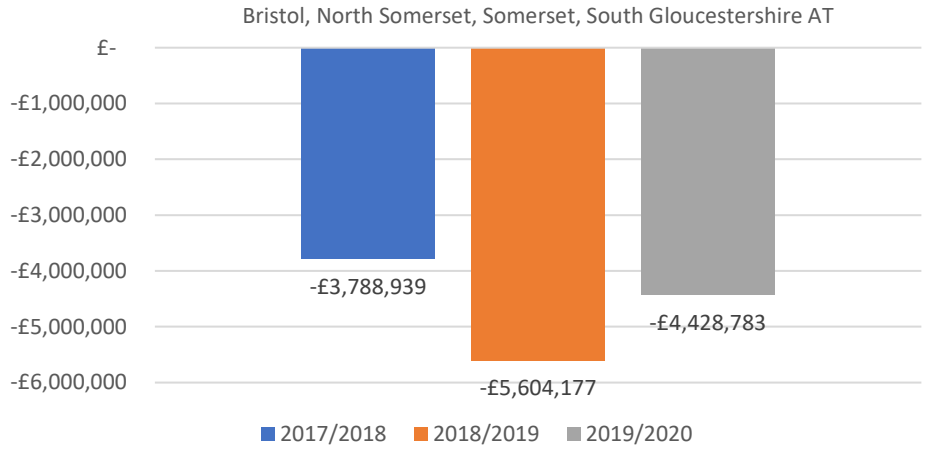
[44] NHS South, Central and West Commissioning Support Unit Oct 2020

Chart 3: Delivered UDAs over last 4 years as % of contracted UDAs by South West Sub Region (Source NHSE&I Aug 2020)



7.17 The chart below sets out the UDA clawback value in £s by sub-region across the South West. It shows a sizeable level of claw back each year, with 2018/2019 being a particularly significant year with £5,604,177 clawed back by the NHS for the under delivery of UDAs.

Chart 4: UDA Clawback Value (£) by Subregion 2017-2020 Source NHS England Aug 2020



Cross-Border Flow and Seasonal Variation

7.18 As people may visit a dental practice anywhere in the country, it is useful to explore cross border flows for three reasons. First, large numbers of people accessing services from outside an area can limit access to services for residents. Secondly, such patterns may indicate a lack of service availability or poor service quality in the area. Third, some areas in the South West have seasonal migrant workers and others, including Somerset are popular holiday destinations. This may lead to seasonal variations in access to services, especially urgent care.

Complexity of care

7.19 The proportion of people having Band 1 courses of treatment is higher in all areas of the South West relative to the England percentage, but Somerset is below the South West percentage. Urgent care is above both the England and the South West percentages, and this would suggest that people needing more complex care may be facing additional barriers to accessing it. Therefore, NHS England and NHS Improvement may want to consider undertaking a health equality audit to ensure the equitable availability and accessibility to NHS primary dental care in Somerset.

Table 15: Proportion of courses of treatment in each band (adults and children combined)

Area	Band 1	Band 2	Band 3	Band 4 Urgent
NHS Somerset CCG	61.21%	24.51%	3.95%	9.86%
South West	62.24%	24.14%	3.71%	9.58%
England	59.96%	25.48%	4.78%	9.47%

Evidence based prevention and care

Fluoride varnish application

7.20 Evidence-based guidance recommends application of fluoride every six months for all children aged three years and above and more frequently at risk of decay. Fluoride varnish application is also recommend twice a year for vulnerable adults. Fluoride varnish application two-three times a year can reduce tooth decay by 33% in baby teeth and 46% in adult teeth[45].

7.21 In 2018-2019 there were 599,188 fluoride varnish application in the South West. Unfortunately this data is not available for 2019-2020. In 2018-2019 the % of the population that have received fluoride varnish was 42.8% of children and 1.2% of adults. In Somerset there were 66,254 representing 11.1% of the regional applications. 7.3% were for adults and 92.7% were for children. This represented 11.8% of the population - 1.1% of adults, slightly below the South West proportion and 55.5% of children, above the South West proportion.

Table 16: Fluoride varnish application Children and Adults by STO 2018-19

Fluoride Varnish	Fluoride Varnish Count	Regional %	Fluoride varnish as a % of the population
NHS Somerset CCG	66254	11.1%	11.8%
Adult (over 18)	4823	0.8%	1.1%
Child (u18)	61431	10.3%	55.5%
South West	599188	100.0%	9.5%
Adult (over 18)	59207	9.9%	1.2%
Child (u18)	539981	90.1%	42.8%

[45] https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD002279.pub2/full

7.22 NICE has published evidence-based guidelines for dental recall intervals. Adults should be seen for a dental recall at intervals from 3 to 24 months and children should be seen at intervals from 3 to 12 months depending on their level of risk of oral disease. Therefore, adults whose care falls under Band 1, that is those people with low levels of disease activity, should usually have a recommended recall interval of 24 months.

7.23 The table below presents the proportion of people re-attending every three months in the South West. The data shows that the proportion of people seen every three months is comparable with the England average. This is despite a greater proportion of Band 1 courses of treatments being provided in the region. What stands-out, is the recall intervals for children compared with the England-average.

Table 17: 3-month recall intervals (high-risk) patients 2019 Source: NHS England

Area	Children (%)	Adults (%)
Bristol, North Somerset, Somerset and South Gloucestershire	6.6	12.7
England	7.0	12.7

Other primary care services

7.24 Primary care activity is also provided at Bristol Dental Hospital and its associated outreach clinics, predominantly by dental students supervised by GDC registered staff.

7.25 In addition, many NHS dental practices provide primary care dentistry on a privately funded basis and there are also several wholly private dental practices. There is no local data available on private dentistry activity and costs.

Domiciliary services

7.26 Domiciliary oral healthcare is provided to those people who cannot visit a dentist. Care is provided at the location the patient permanently or temporarily resides including patients' own homes, residential units, nursing homes, hospitals and day centres. Adequate provision of these services ensures dental services provide a reasonable alternative route for older people and vulnerable groups in accordance with the Equality Act 2010.

7.27 The Community Dental Service provides domiciliary care in the county. It has been commissioned to provide 412 clinical sessions for approximately 1,236 patients which generated between 1,800 and 2,000 UDAs. Data previously outlined in this section, describes the demographic characteristics of the population with more people of retirement age and less people of working age living in the Somerset. This may suggest greater need for domiciliary care. Therefore, commissioners

might wish to consider if there is adequate provision of domiciliary dental care in Somerset as the older population increases. Work is being done by PHE to review and develop training programme for staff in the domiciliary and care home sector to support residents to get the best oral health care possible.

Unplanned dental care

7.28 Access to urgent care is critical to support the relief of pain and for accidental damage. Patients' use of urgent care services is more complex than just a failure to access preventive or routine care. One in four, (25%), of the adult population in the South West reported that they only went to the dentist when they had a problem (ADHS 2009). In the recent 2018 Adult in Practice survey, 8.2% of patients in the South West stated they had an urgent treatment need compared to 4.9% across England.

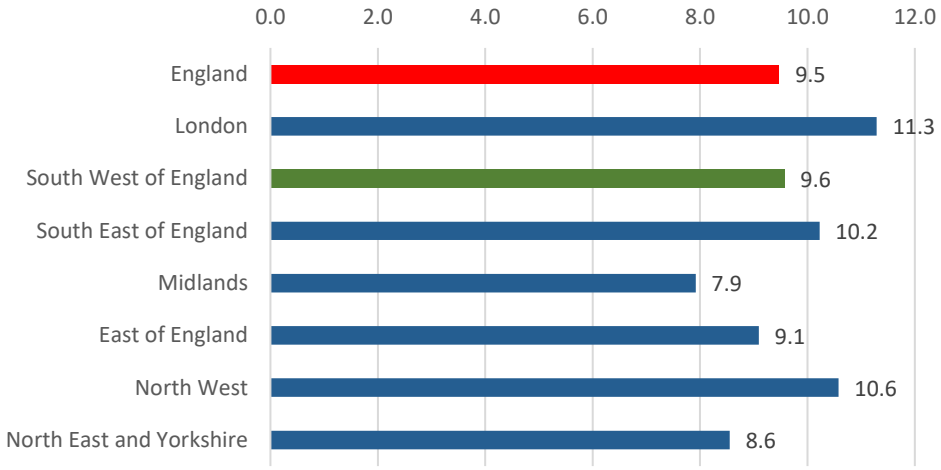
7.29 Across the South West, approximately half of the adult population and a third of the child population have not visited the dentist in the last two years, and thus may not have a regular dentist if a problem occurs.

7.30 Unplanned dental care is best reviewed by assessing the levels of urgent care as per the bands of provision in the dental care system. The table below sets out the number and % of urgent care in 2019-2020 by region. It shows that in the South West 9.6% of dental care was urgent care which is slightly above the proportion of urgent care nationally at 9.5%.

Table 18: Number and percentage of Courses of Treatment by NHS Commissioning Region1 and treatment band, 2019-20 (NHS Dental Services, NHS Business Services Authority (BSA))[46]

Org Name	Urgent	Urgent (%)[47]
England (19/20)	3,638,000	9.5%
England (18/19)	3,621,000	9.1%
South West of England (19/20)	370,000	9.6%
South West of England (18/19)	372,000	9.2%

Chart 5: Percentage of Urgent Care Treatment by NHS Commissioning Regions (% of total Bands) 2019-20



Urgent Dental treatment by type (Child/non-paying Adult/paying Adult)

7.31 Across the South West the profile of urgent care as a proportion of all treatment bands has been taken from the review of treatment bands nationally by region, STP, LA and by Cost of Treatment 2019-2020 (Sum and %)[48].

7.32 In the South West region, the level of urgent care for children was 4% (as compared to England at 4.2%), for non–paying adults it was 16.4% (as compared to England at 16.2%) and for paying adults it was 10.8% as compared to England at 10.5%

7.33 Across the South West there are some variances in the levels of urgent care between children, non-paying and paying adults. The table below compared this STP with the South West's levels of urgent care activity by type of patient.

[46] Data is affected by COVID-19.
[47] Figures presented are rounded
[48] Source: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-dental-statistics/2019-20-annual-report : NHS Dental Statistics for England - 2019-20: Annex 3 (Activity)

Table 19: Review of Urgent care treatment Bands by STP in the South West by Cost of treatment 2019-2020 (Sum and %) NHS Digital 2020

Row Labels	Type	% within Type
NHS Somerset CCG		
Urgent/Occasional	Child	4.2%
	Non-paying adult	16.4%
	Paying adult	11.0%
South West		
Urgent/Occasional	Child	4.0%
	Non-paying adult	16.4%
	Paying adult	10.8%

7.34 In Somerset in 2019/2020, 4.2% of urgent care was for Children compared to 4.4% for the South West, 16.4% was for non-paying adults as compared to 16.4% for the South West and 11.0% was for paying adults compared to 10.8% in the South West.

Oral Cancer

7.35 Mouth cancers make up 2% of all new cancers in the UK[49]. Oral cancer rates in the South West are 14.9 per 100,000 – lower in comparison to England (at a rate of 15.0 per 100,000), in Somerset it is 13.07 higher than the South West rate and lower than the England rate.

8 Oral Health Improvement

8.1 Somerset County Council produced 'Improving Oral Health in Somerset' in 2015-2018 and updated in 2019. The aim of this strategy is to help promote good oral health in a planned and coordinated way across Somerset.

8.2 The priorities for the strategy include:

- Improve diet and reduce the consumption of sugary foods, drink, alcohol and tobacco.
  - Healthy food and drink policies in early years, school and workplace settings.
  - 'Make Every Contact Count': Consider oral health in all contacts.
  - Signpost those ready to change their behaviours to services that can support them e.g. stop smoking services.

[49] State of mouth Cancer UK Report 2018-2019 https://www.dentalhealth.org/Handlers/Download.ashx?IDMF=21dc592b-d4e7-4fb2-98a9-50f06bed71aa

- Raise awareness of the risk factors and early symptoms of oral cancer across all age groups.

- Increase the availability of fluoride.
  - Ensure all young children and parents have access to fluoride toothpaste and tooth-brushing information.
  - Provide targeted, community-based fluoride varnishing and education programmes.
  - Signpost people to primary dental care for further oral health education and preventive treatments (such as fluoride varnishing and fissure sealants).

- Improving oral hygiene
  - Ensure that the wider professional workforce have access to training and information on oral health.
  - Promote supervised tooth-brushing schemes in all early years settings and primary schools.
  - Support supervised tooth-brushing schemes in schools with children at increased risk of poor oral health.
  - Integrate oral health education and dental signposting into home visits and assessments by health & social care workers.

- Addressing inequalities in oral health
  - Promote good oral health behaviours and attendance at a dentist throughout the life-course (prenatally onwards).
  - Provide targeted and evidence-based interventions to populations with increased risk of poor oral health (e.g. supervised tooth-brushing schemes and community fluoride varnishing).
  - Equip the wider health and social care workforce with the knowledge and skills to recognise those at risk of poor oral health and its link with neglect and/or complex social circumstances.
  - Ensure all dental, health and social care staff receive safeguarding training and are aware of how to refer those who raise concern.

- Increasing access to dental services, thus requiring all services to seize opportunities to:
  - Signpost parents to primary dental care.
  - Ensure that information is available on how to access dental care, including the associated costs/eligibility for support with healthcare costs.
    - Information should be available in easy to read and language appropriate formats.

8.3 Currently Somerset County Council (SCC) commission oral health improvement services that deliver specific activities aimed at reducing inequalities in oral health in Somerset. This activity includes:

- Universal toothbrush distribution at 12 months.
- Oral health training and supervised tooth brushing support in Special Schools.
- Targeted fluoride varnishing scheme for 3 year olds.
- Targeted training of professionals who support higher need groups.
- Oral health promotion eLearning – workforce development.

8.4 The oral health improvement service contract, that covers all ages, has been extended for a further two years 2019-2021. The objective of this service is to reduce inequalities in oral health through evidence-based interventions with populations at risk of poor oral health (as identified within this strategy).