Oral health in East Anglia

A report prepared for NHS England Anglia Area Team.

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Summary
Oral health in East Anglia is generally good. This, however, masks oral health inequalities and a small number of people bear the burden of disease. They are children and adults living in material and social deprivation and people in at risk groups, such as older people and people living with disability or in long term institutional care. This health divide is of concern.

Access to dental services is variable across East Anglia and, for some marginalised groups, access is poor. Not much is known about the quality of these services or how accessible patients find them. Referral criteria and access for specialist dental services vary.

Access to a range of dental services is available but there is little evidence that this is meeting the differing needs of the population. At present these inequities in service provision have the potential to increase rather than decrease oral health inequalities.

The quality and availability of information both about the oral health status of the population and the services provided is poor and provides little information for future commissioning of these services.

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1.0 Oral Health

1.1 Oral health of children

The dental health of children in East Anglia is generally good. The most recent data (2011/12) shows that the majority of 5 year old children in Cambridgeshire, Suffolk and Norfolk were free of decay. Only Peterborough was worse than the national average. The average number of decayed missing and filled teeth (d3mft) in five year old children showed a similar picture with only Peterborough outside the England average (see Table 1).

Table 1: Percentage of 5 year old children who are decay free and average number of decayed missing or filled teeth per child of children living in East Anglia 2011/2012

<table>
<thead>
<tr>
<th>Indicator</th>
<th>England</th>
<th>Cambridgeshire</th>
<th>Suffolk</th>
<th>Norfolk</th>
<th>Peterborough</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of 5 year olds who are decay free</td>
<td>73</td>
<td>86</td>
<td>83</td>
<td>73</td>
<td>64</td>
</tr>
<tr>
<td>Average d3mft</td>
<td>0.9</td>
<td>0.5</td>
<td>0.6</td>
<td>0.9</td>
<td>1.1</td>
</tr>
</tbody>
</table>


At a lower tier level the picture is more varied. Children living in Great Yarmouth, Norwich and Peterborough had higher levels of dental decay that the average for England.

1.1.1 Inequalities in oral health in children.

Whilst children in East Anglia have, on average, good dental health, with little or no decay, this masks an underlying trend of worse decay in those children who have any decay.

Figure 1 shows the average number of teeth with decay (mean d3mft, decayed, missing and filled teeth) but this is skewed by the large number of children with no decay. If we only consider those children with decay, and measure their number of decayed teeth, then the average increases markedly (mean d3mft (% d3mft >0)). It can be seen from Figure 1 that those children in Cambridge, Fenland, Breckland, Great Yarmouth, Norwich and Suffolk Coastal who have decay have a higher level of decay than the England average. This suggests that a small number of children experience most decay. Children who have on average 3 to 4 decayed teeth are more likely to be living in deprivation and are less likely to access dental services. When they do access services they may not receive definitive treatment.
1.2 Oral health of adults

Oral health in adults in East Anglia is generally good. The decennial national Adult Dental Health Surveys, (ADHS most recently in 2009), found that twenty per cent of adults in the East of England had excellent oral health. This is the highest proportion of any region in England.

However a minority of adults, like children, carry the burden of disease. While the mean DMFT (decayed missing and filled permanent teeth) for the population was 0.5 the average for those with decay was 2.2 teeth

1.3 Children and adults at risk of poor oral health

Children at risk of poor oral health are those living in areas of material and social deprivation, children with disabilities, looked after children and children at risk of neglect or abuse. There is no local data available about the oral health of these groups of children but this relationship is supported by various studies and the degree of poor oral health in these children is closely associated with deprivation.

Adults from vulnerable groups are most at risk of poor oral health. They include adults living in areas of material and social deprivation, people who have a learning disability, people with mental illness, people in long term institutional care, including residential care, psychiatric hospitals and prisons, homeless people, some ethnic minority groups and the travelling community. There is no local data available about the oral health of these groups in the population. However a review of the literature suggests that they are likely to
have poorer oral health than the rest of the population and are also likely to have more difficulty accessing dental care. \(^7\) \(^8\) \(^9\) \(^10\) \(^11\) \(^12\) \(^13\) \(^14\) \(^15\) \(^16\) \(^17\) \(^18\) \(^19\) \(^20\)

The proportion of people retaining a useful number of natural teeth into retirement age has increased dramatically during the past forty years. \(^21\) As the number of older people rises and their complexity of care increases there will be an associated rise in demands on the service and a change in the nature of care required. \(^22\) \(^23\) \(^24\)

There are nearly 90,000 people over the age of 75 year living in Norfolk and in Suffolk more than 70,000. These figures are likely to increase by 30% by 2021.

2.0 Dental Health Services

2.1 Access to dental services

The Department of Health defines access as “the percentage of people in the population who have seen the dentist within the last 24 months”. This is a very narrow definition of access. The priorities for dental service provision are access to:

- Routine and preventive services
- Urgent care services
- Specialist services

2.1.1 Availability of NHS dental services

Since the inception of the new dental contract in March 2006 the number of dentists with NHS activity has increased everywhere in East Anglia apart from in Peterborough (see Table 2). It is interesting to note that Peterborough, with the highest level of childhood decay, has a much higher number of dentists per 100,000 population than England.

Table 2: The number of dentists with NHS activity Cambridgeshire, Norfolk, Peterborough, Suffolk and Great Yarmouth and Waveney March 2007 and March 2012

<table>
<thead>
<tr>
<th></th>
<th>March 2007</th>
<th>Population per dentist</th>
<th>Dentists per 100,000 of population</th>
<th>March 2012</th>
<th>Population per dentist</th>
<th>Dentists per 100,000 of population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of dentists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>20,160</td>
<td>2,518</td>
<td>40</td>
<td>22,920</td>
<td>2,279</td>
<td>44</td>
</tr>
<tr>
<td>Cambridgeshire</td>
<td>232</td>
<td>2,521</td>
<td>40</td>
<td>331</td>
<td>1,862</td>
<td>54</td>
</tr>
<tr>
<td>Norfolk</td>
<td>301</td>
<td>2,444</td>
<td>41</td>
<td>350</td>
<td>2,186</td>
<td>46</td>
</tr>
<tr>
<td>Peterborough</td>
<td>90</td>
<td>1,861</td>
<td>54</td>
<td>88</td>
<td>1,971</td>
<td>51</td>
</tr>
<tr>
<td>Suffolk</td>
<td>249</td>
<td>2,335</td>
<td>41</td>
<td>315</td>
<td>1,911</td>
<td>52</td>
</tr>
<tr>
<td>Great Yarmouth and Waveney</td>
<td>92</td>
<td>2,305</td>
<td>43</td>
<td>129</td>
<td>1,664</td>
<td>60</td>
</tr>
</tbody>
</table>

2.1.2 Location of NHS dental practices

Most NHS dental practices are located in the towns and cities. There is good provision in some of the most deprived areas of East Anglia for example Peterborough, Great Yarmouth and Lowestoft but not in others for example Wisbech, Kings Lynn and Thetford. Map 1 shows the distribution of NHS dental practices mapped to deprivation across the Anglia area and demonstrates that dental practices are mainly based in urban areas and do not map to the areas of highest deprivation. It is unclear whether this mis-match in provision contributes to poor dental health but should be considered when planning new services.

Map 1: Treatment locations and IMD Score 2010 by LSOA 2013/ 2014

2.1.3 Barriers to Dental Care

Access to dental services is not just about the location of the practices. Most dental practices in East Anglia are situated in towns and cities where most of the population reside yet still only just over half the population in East Anglia (54.2%) visit the dentist in a two year period. The way people use services
depends on other factors as well including acceptability, affordability, availability, accessibility and the appropriateness of the service offered.

Obstacles to attending the dentist include dental anxiety, cost of treatment and the attributes of the dental practice. Just over a quarter of adults (26%) surveyed in the ADHS 2009 said that the type of dental treatment they had opted for in the past had been affected by cost and almost a fifth (19%) said they had delayed dental treatment for the same reason.

The rural nature of the area and poor public transport will affect peoples’ ability to access dental services as well as lack of availability of appointments at evenings and weekends.

Most NHS dental services are provided under non-time limited GDS contracts and opportunities to renegotiate these to improve access are very limited.

3.0 Access to routine and preventive dental care

3.1 Access to routine and preventive dental care for children

There was little change in the percentage of the child population visiting the dentist between March 2011 and March 2014 in East Anglia. Overall the percentage of the child population visiting an NHS dentist has remained stable at 67.4%

Figure 2: Child Access Rates Trend by Local Authority in East Anglia 2011-2014
The lowest percentage of the child population visiting an NHS dentist (< 60%) was in Cambridge, Forest Heath and Kings Lynn and West Norfolk. This may be due to private provision so might not reflect poor access.

The majority of children who attended a dental appointment (72.1%) receive a Band 1 course of treatment which may include an examination, diagnosis (including X rays), advice on how to prevent future problems, a scale and polish and application of fluoride varnish or fissure sealant. A further 22.7% received a Band 2 course of treatment which will include everything from Band 1 plus any further treatment such as fillings, root canal work or removal of teeth.

Delivering Better Oral Health: an evidence based toolkit for prevention recommended that all children over 3 years should receive a professional application of fluoride varnish to the teeth twice a year (DBOH). Children aged from 7 years who give concern to the dentist, including those with obvious current active decay and those with special needs, should have their permanent molar fissures sealed. There is no local data about how children with special needs access dental services.

However, compared to national averages, the percentage of children living in East Anglia who receive a preventive intervention as part of a course of treatment is low and about half the rate for England (see Table 3).

Table 3: Rate of fluoride varnish or fissure sealant application per 100 courses of treatment by age group for children resident in East Anglia 2013/2014

<table>
<thead>
<tr>
<th></th>
<th>Children aged 0-2 years</th>
<th>Children aged 3-5 years</th>
<th>Children aged 6-12 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>England</td>
<td>E. Anglia</td>
<td>England</td>
</tr>
<tr>
<td>Fissure sealants</td>
<td>0.0</td>
<td>0.0</td>
<td>0.1</td>
</tr>
<tr>
<td>Fluoride Varnish</td>
<td>5.4</td>
<td>2.6</td>
<td>24.6</td>
</tr>
</tbody>
</table>


### 3.1.1 Access to routine and preventive dental care for looked after children

There is a requirement that looked after children have an annual health assessment and that this should include a dental check-up. Currently this requirement is not being met and figures for Norfolk and Suffolk are low, 65.2% and 58.1 % respectively (see Table 4). Interestingly, again, Peterborough achieves the highest take up of annual health assessment compared to other areas, and much higher than then England average. It should be noted that attendance at a dental check-up does not provide any information about the quality of care or if any necessary treatment was completed. This group of children is likely to have poorer oral health and, if they are moved between different carers, more erratic and irregular access to dental care.

Table 4: Percentage of looked after children attending a dental check-up 2011 and 2012

<table>
<thead>
<tr>
<th></th>
<th>England</th>
<th>East of England</th>
<th>Cambridgeshire</th>
<th>Norfolk</th>
<th>Peterborough</th>
<th>Suffolk</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>82.4</td>
<td>74.7</td>
<td>92.6</td>
<td>27.2</td>
<td>84.4</td>
<td>68.8</td>
</tr>
<tr>
<td>2012</td>
<td>82.4</td>
<td>79.9</td>
<td>92.4</td>
<td>65.2</td>
<td>93.2</td>
<td>58.1</td>
</tr>
</tbody>
</table>

Source: Fingertips 2012
3.2 Access to routine and preventive dental care for adults

Access was highest in Waveney and Great Yarmouth and lowest in Cambridge, Fenland, Forest Heath, Kings Lynn and West Norfolk and Peterborough where less than fifty per cent, and in some case less than forty per cent of the population have visited the dentist within the last two years (see Figure 3). Again this does not include access to private services for which there is no data.

Overall the percentage of the adult population visiting an NHS dentist within the last 24 months has not changed and remains stable at 54.2%. A visit to the dentist also provides the opportunity to deliver evidence based preventive interventions such as oral hygiene and diet advice smoking cessation advice and scaling and polishing (DBOH) which will be missed if access is limited.

Figure 3: Adult Access Rates Trend by Local Authority in East Anglia


3.3 Access to community based preventive programmes for adults and children

Local authorities are responsible for improving the health of the people in its area and the provision of oral health promotion programmes. (SI 13094. 2012). The provision of these services across East Anglia including fluoride varnish and tooth brushing schemes is variable.
3.4 Access to urgent dental care for adults and children

Access to urgent care is a priority for the relief of pain and for accidental damage. One in four, (26%), of the adult population in the East of England reported that they only went to the dentist when they had a problem. (ADHS 2009). Just under half the population in East Anglia (45.8%) has not visited the dentist in the last two years and may not have a regular dentist when they have a problem.

Patients’ use of urgent care services is more complex than just a failure to access preventive or routine care and a range of services should be available to meet the needs of patients who choose to access dental services in different ways.

3.4.1 Access to urgent dental care for children

In 2013/2014 4.7% of all courses of dental treatment provided for children were for urgent care. This compares with an England average of 4.6 %.

3.4.2 Access to urgent dental care for adults

Figure 4 shows the percentage of courses of treatment that were recorded as urgent treatment and compares this with national levels.

Figure 4: Percentage of courses of treatment for Band I urgent courses of treatment for adults (March 2014)
Levels for urgent care were higher than the national average in Fenland (5,466 claims), Great Yarmouth (10,078 claims), Ipswich (8,730), Kings Lynn and West Norfolk (8,434), Norwich (11,148), Peterborough (10,026) and Waveney (10,933). Higher levels of urgent care can indicate an issue with the quality of diagnosis and treatment planning, patients not able to access routine dentistry or patient choice. Dental Access Centres (DAC) in Wisbech, Cambridge, Kings Lynn and Norwich only provide access to urgent care and this may have skewed the data.

Research indicates that DACs are offering treatment to a different population of patients from that seen in neighbouring ‘high street’ practices. Patients attending DACs were younger and from a more disadvantaged background. They had worse oral health, experienced more frequent episodes of dental pain, were more likely to be dentally anxious and had different attitudes to dental health than their ‘high street’ counterparts. It is important that access to urgent care is offered to patients when they need it and to enable different sectors of the population to access dental services in different ways.

4.0 Access to specialist services

4.1 Access to domiciliary dental services

Domiciliary dental care can be the only care available to patients who are housebound. Poor access to timely domiciliary services has the potential to increase oral health inequalities in the most vulnerable groups of patients, particularly elderly people and those suffering from dementia. There is a clear and consistent relationship between good oral health, the retention of natural teeth and a healthy diet and good nutrition, especially in older people.

In future there may be greater demand for these services as population projections indicate that by 2021 the population of adults over 75 years living in East Anglia is likely to increase by about 30% (source: http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Subnational+population=Projections#t) (KITS PHE)

Domiciliary visits undertaken in East Anglia included an examination,(64.4%), provision of a denture(12%), extractions (6%) and permanent fillings (11%). Most visits, (72%) were provided for people who are seventy five years and over.

The level of service across East Anglia varied and was not associated with age, level of deprivation or level of disability in the population (see Figure 5). Areas with the highest levels of deprivation (e.g. East Cambridgeshire, Fenland and Ipswich) or with high numbers of people aged over 75 years (e.g. South Suffolk and Suffolk Coastal) had little or no service provision.
4.2 Access to anxiety management services

In East Anglia 232,796 (12%) of the adult population (19 years and above), (ONS 2011), was likely to suffer from dental phobia and avoid dental care as a result. (ADHS 2009). The ADHS 2009 also found that the proportion of adults with extreme dental anxiety varied by socioeconomic occupation of the household and was higher in adults from routine and manual occupation households (15%) than professional and managerial occupation households (10%) 30 31 32 33

The provision of adequate anxiety control is an integral part of the practice of dentistry. Child dental anxiety, for example, is widespread and many anxious children, and adults, can be satisfactorily treated using behaviour management techniques.

Dental anxiety is a potential barrier to those seeking dental care and its association with oral health is of central importance. Adequate provision of anxiety management services, including behaviour
management and sedation techniques is important in reducing barriers to accessing dental care as well as reducing the health inequalities associated with deprivation.

4.2.1 Sedation services as an adjunct to dental services

Some groups of patients will have reasons, other than anxiety, to need sedation to complete dental treatment e.g. to manage the pain and discomfort of surgical dentistry where local analgesia alone is not adequate or effective. These groups may also include those with learning or physical disabilities who may benefit from the provision of sedation services. When sedation services are offered the quality of the clinical dental care provided in these situations must be excellent to minimise the risk of repeat procedures.

4.2.2 Sedation services for children

Very few children undergo sedation as part of a course of dental treatment. Only 0.2 per cent of courses of treatment provided for children in East Anglia include sedation compared with 0.5 nationally.

7% of courses of treatment including sedation are provided for children up to the age of five years. Most (61%) are provided for children between the ages of six and twelve years and are mostly for fillings (42%) and extractions (67%).

4.2.3 Sedation services for adults

Only 0.1% of adults who attend for NHS dental treatment in East Anglia receive sedation as part of that course of treatment. Most of the care provided under these arrangements is for extractions, (71%), or fillings (44.5%). Nearly half of the patients, (49%) are aged 25 to 44 years.

Provision across the area shows a great deal of variation (see Table 5) and this may reflect ease of access to NHS services rather than patient need. It is not known how many patients may visit private providers to use these services.

Patients in seven districts have almost no access to sedation services and this is unlikely to be related to need. Areas with higher deprivation and consequently higher need and higher anxiety levels such as Fenland, East Cambridgeshire, Peterborough, have very limited access to sedation services and this is of concern (see Table 5).
Table 5: Number of courses of treatment provided by Lower Tier Authority in East Anglia including sedation services 2013/2014

<table>
<thead>
<tr>
<th>Lower tier LA</th>
<th>Total claims with sedation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adults</td>
<td>Child</td>
</tr>
<tr>
<td>Babergh</td>
<td>18</td>
<td>-</td>
</tr>
<tr>
<td>Breckland</td>
<td>128</td>
<td>1</td>
</tr>
<tr>
<td>Broadland</td>
<td>200</td>
<td>5</td>
</tr>
<tr>
<td>Cambridge</td>
<td>15</td>
<td>-</td>
</tr>
<tr>
<td>East Cambridgeshire</td>
<td>17</td>
<td>-</td>
</tr>
<tr>
<td>Fenland</td>
<td>16</td>
<td>-</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>36</td>
<td>-</td>
</tr>
<tr>
<td>Great Yarmouth</td>
<td>93</td>
<td>28</td>
</tr>
<tr>
<td>Huntingdonshire</td>
<td>38</td>
<td>-</td>
</tr>
<tr>
<td>Ipswich</td>
<td>105</td>
<td>-</td>
</tr>
<tr>
<td>Kings Lynn and West Norfolk</td>
<td>43</td>
<td>1</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>27</td>
<td>-</td>
</tr>
<tr>
<td>North Norfolk</td>
<td>133</td>
<td>-</td>
</tr>
<tr>
<td>Norwich</td>
<td>340</td>
<td>-</td>
</tr>
<tr>
<td>Peterborough</td>
<td>30</td>
<td>-</td>
</tr>
<tr>
<td>South Cambridgeshire</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>South Norfolk</td>
<td>167</td>
<td>2</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>60</td>
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</tr>
<tr>
<td>Suffolk Coastal</td>
<td>39</td>
<td>3</td>
</tr>
<tr>
<td>Waveney</td>
<td>169</td>
<td>-</td>
</tr>
</tbody>
</table>


4.3 Dental treatment provided under general anaesthesia for children

Dental extractions, carried out under general anaesthesia (GA), in children with decayed teeth occur when all other interventions have failed. The decision to use GA is complicated by the knowledge that there is a small but real risk of death associated with GA. The knowledge that the majority of operative care can be carried out using either local analgesia (LA) or LA with conscious sedation sets dentistry aside from other paediatric surgical specialties where GA is the norm.34

The commonest reason for primary-school-aged children being admitted to hospital is to have multiple teeth taken out under general anaesthesia. Dental extractions carried out on children under the age of ten are most likely to be because of dental decay. Extractions for older children could also include teeth removed to relieve crowding as part of a course of orthodontic treatment. Approximately 0.1 to 0.6% of the child population visit hospital to have dental extractions under general anaesthesia each year. These figures are likely to be an under estimate as any extractions carried out as part of a Personal Dental Services (PDS) salaried dental service contract may not be recorded.
Table 6: Number of finished consultant episodes (FCEs) for children and adolescents aged 0-19 years in East Anglia admitted to hospital for extraction during 2012/2013

<table>
<thead>
<tr>
<th>Lower tier LA: Lower tier LA</th>
<th>0-4</th>
<th>5-9</th>
<th>10-14</th>
<th>14-19</th>
<th>Total 2012/13</th>
<th>Total 2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>28</td>
<td>16</td>
<td>19</td>
<td></td>
<td>63</td>
<td>65</td>
</tr>
<tr>
<td>Breckland</td>
<td>25</td>
<td>19</td>
<td></td>
<td></td>
<td>44</td>
<td>41</td>
</tr>
<tr>
<td>Broadland</td>
<td>15</td>
<td>12</td>
<td></td>
<td></td>
<td>27</td>
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</tr>
<tr>
<td>Cambridge</td>
<td>14</td>
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<td></td>
<td></td>
<td>24</td>
<td>44</td>
</tr>
<tr>
<td>East Cambs</td>
<td>6</td>
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<td>9</td>
<td></td>
<td>36</td>
<td>31</td>
</tr>
<tr>
<td>Fenland</td>
<td>20</td>
<td>36</td>
<td>28</td>
<td>16</td>
<td>100</td>
<td>107</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>10</td>
<td>10</td>
<td></td>
<td></td>
<td>20</td>
<td>32</td>
</tr>
<tr>
<td>Great Yarmouth</td>
<td>6</td>
<td>22</td>
<td>28</td>
<td></td>
<td>46</td>
<td>66</td>
</tr>
<tr>
<td>Huntingdonshire</td>
<td>23</td>
<td>62</td>
<td>57</td>
<td>32</td>
<td>174</td>
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<td>Ipswich</td>
<td>29</td>
<td>115</td>
<td>46</td>
<td>24</td>
<td>214</td>
<td>172</td>
</tr>
<tr>
<td>Kings Lynn and West Norfolk</td>
<td>9</td>
<td>51</td>
<td>70</td>
<td></td>
<td>130</td>
<td>125</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>9</td>
<td>19</td>
<td>14</td>
<td></td>
<td>42</td>
<td>58</td>
</tr>
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Source: http://www.nwph.net/dentalhealth/

The picture is complex. Increasing numbers of children undergoing dental extractions under general anaesthesia may not, in itself, reflect a growing burden of disease. Increasing provision and improved access to general dental services may increase the number of children referred on for the service who otherwise may not have received treatment.

The majority undergoing treatment under GA however are likely to be children living in deprived areas who suffer the poorest oral health and who are less likely to visit the dentist unless there is a problem.

Following the publication of “A Conscious Decision: A review of the use of general anaesthesia and conscious sedation in primary dental care” dental treatment can only be provided under GA in a hospital with a critical care facility. For children living in rural areas without a family car and poor public transport accessing these services, especially in a timely manner, can be difficult. Any delay in the provision of care can result in pain, infection, sleepless nights and failure to thrive.
5.0 General principles

Oral diseases are important public health issues as they are among the most commonly found chronic
diseases and are almost entirely preventable. The causal relationships between sugar and dental decay and
mum disease and poor oral hygiene, for example, are well understood.

Primary prevention, employing the principles of universal proportionalism and integrating oral health with
generic health, using the common risk factor approach (CRFA) is the most effective way of improving the
oral health of the population of East Anglia. Working with other agencies such as local authorities is
important to tackle these common risk factors such as poor diet, tobacco use, poor hygiene, alcohol
consumption and injuries, factors which are also associated with obesity, cancer, heart disease, diabetes
and strokes. 36

Secondary prevention, using targeted interventions such as fluoride varnish and brushing schemes, are
important in areas where oral health is worse.

Access to high quality dental services, delivering consistent oral health promotion interventions such as
preventive advice, tooth brushing instruction and fluoride varnish applications is key. 37

6.0 Key messages

• **Prevention:**
  Oral health problems are not being prevented in adults and children from marginalised and deprived
groups in East Anglia.

• **Access:**
  Dental service provision in East Anglia bears little relation to oral health need. There are discrepancies
  between the availability of services and need, and patients do not always get the right care when they
  access dental services.

• **At risk groups:**
  People in marginalised or deprived groups in East Anglia are more likely to have poor oral health and
  less likely to access services. This includes people living in areas of material and social deprivation as
  well as those with physical and learning disabilities, dementia sufferers or people in long term
  institutional care.

• **Data**
  Information about services and the quality of those services is limited. There is some local data about
  the oral health of children but no local data available about the oral health of adults.
7.0 References

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