

Oral Health Strategy 2023 – 2028

Blackpool Council



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Executive Summary

Organisation of dental services

From April 2023 integrated care boards (ICBs) took over responsibility for commissioning primary, secondary and community dental services. General dental practices are private businesses and can offer both NHS and private dental care, or opt to provide just NHS or private care exclusively. The Government launched [a plan to recover and reform NHS dentistry](#) on 7 February 2024. One component of the plan will fund more than 1.5 million additional dentistry treatments, so that anyone who has been unable to access NHS dental care in the last two years will be able to do so.

Although not responsible for clinical services, local authorities are statutorily required to provide or commission oral health promotion programmes to improve the health of the local population, to an extent that they consider appropriate in their areas. They are also required to provide or commission oral health surveys to facilitate assessment and monitoring of oral health needs and the planning and evaluation of oral health promotion programmes and dental services.

Why do we need an oral health strategy?

Despite many positive changes to the landscape of oral health over the years, particularly with the introduction of fluoride in toothpaste in the 1970's, there is still more work to be done. Achieving twice-daily brushing, an excess of sugar in our food and drink, and smoking remain difficult challenges to oral health.

Many factors affect a person's ability to care for their oral health, for example, poverty, isolation, poor mobility and poor physical or mental health. This strategy looks at ways we can help to overcome some of the barriers to having good oral health and gives everybody the opportunity to access the information and support they need to improve their oral health.

Our vision for Blackpool

The long term vision for Blackpool is to reduce the prevalence of, and the resultant risks, from poor oral health. We would wish to see all of our children in Blackpool growing up with a full set of healthy teeth as they reach adulthood, so that they become adults with healthy and strong teeth and gums.

The Guiding Principles

Throughout the development of this strategy, it was important to ensure key principals were reflected:

- It was developed by working together with a multi-disciplinary steering group with representatives from services and organisations who are interested in improving oral health for all residents of Blackpool. This group will also share decision making over the time frame of the strategy.
- It is based on what the data tells us about levels of dental disease within the authority.
- It describes what works well to improve oral health. The preventative interventions included are based on evidence from national research.
- It focuses on adding to what is already being done.
- It supports existing national and local strategies where there is a connection with oral health.
- It outlines some of the challenges around dental services and the impact of the COVID-19 pandemic.
- It is designed for all residents of Blackpool and for health and social care professionals working in the authority.

What are we going to do?

To achieve our ambitions, we have developed actions that reflects both local need and national guidance and recommendations. These recommendations formed the basis for developing the local action plan in collaboration with partners in the steering group.

It is also important that we work with our residents, recognising the individual strengths and assets of communities in different parts of the authority to:

- Ensure people living in Blackpool, and staff working here, are provided with opportunities to play a role in the development of oral health promotion for themselves and their families.
- Empower communities by listening to, and acting on, the feedback we gather.
- Reflect data, particularly about high risk groups and develop actions targeted towards these groups.
- Use existing information from research on what is good practice, but also look at what works best locally. For example, working with early years settings, schools, residential homes, the homeless to explore how interventions could be implemented.
- Guide service providers in how they can ensure their staff have the skills and knowledge required to improve oral health for service users.
- Build on existing assets within our communities. We will engage and work with community groups to ensure this. For example, linking in with and supporting family hubs and the start for life programme.
- Have a live action plan which can be updated to reflect engagement work and feedback from residents, staff and health and social care providers.

Governance and Performance Monitoring

A multidisciplinary Oral Health Steering Group was established to develop the Strategy and Action Plan. This group will continue to meet on a regular basis to monitor the Action Plan.

The Chair of the Steering Group also attends the Health and Wellbeing Board and will report progress to the Board.

Introduction

The Health and Social Care Act (2012) conferred the responsibility for health improvement, including oral health improvement to local authorities.

It is well recognised that oral health is an important part of general health and wellbeing. Poor oral health can affect someone's ability to eat, speak, smile and socialise normally, for example, due to pain or social embarrassment. Oral health problems include gum (periodontal) disease, tooth decay (dental caries), tooth loss and oral cancers.

Many of the risk factors associated with poor oral health – diet high in free sugars, oral hygiene, smoking, alcohol, stress and trauma – are the same as for many chronic conditions, such as cancer, diabetes, respiratory disease and heart disease. As a result, interventions that aim to tackle these risk factors (taking a 'common risk factor approach') will improve general health as well as oral health (Watt and Sheiham 2012).

Oral diseases are largely preventable; and there is a need to develop interventions to achieve sustained and long-term improvements in oral health, and so reduce (health) inequalities. To do so, requires partnership action to address the wider determinants of health, ranging from economic and social policy change (creating healthier environments), to the adoption of healthier behaviours by individuals in the population. It is fundamentally important to also focus on upstream factors that create (health) inequalities and cause both poor general health and oral health.

Our vision

The long term vision for Blackpool is to reduce the prevalence of, and the resultant risks, from poor oral health. We would wish to see all of our children in Blackpool growing up with a full set of healthy teeth as they reach adulthood, so that they become adults with healthy and strong teeth and gums.

Aim of the strategy

The recommendations in this strategy aim to:

- promote and protect oral health by improving diet and reducing consumption of sugary food and drinks, alcohol and tobacco (and so improve general health too)
- improve oral hygiene
- increase the availability of fluoride
- lobby for water fluoridation
- encourage people to go to the dentist regularly
- increase access to NHS dental services.
- reduce inequalities in oral health

Links to other National and Local Strategies

Oral diseases share many risk factors with other chronic diseases. For example, excess sugar in the diet is a risk factor for tooth decay and obesity; alcohol is a risk factor in many cancers, including oral cancer and smoking is a main cause of lung disease and periodontal (gum) disease. This strategy, therefore, supports national strategies such as the Government food strategy 2022 and smokefree England ambitions. It also supports, and is supported by, local strategies.

Blackpool Alcohol Strategy 2019-2023

Blackpool Drug Harm Reduction Strategy 2023-2025

Blackpool Healthy Weight Strategy 2023-2028

Childhood Obesity: A plan for action (HM Government, 2017)

Tackling obesity: empowering adults and children to live healthier lives (DHSC, 2020)

Blackpool Family Hubs and Start for Life Programme

[NHS Core20PLUS5 – Reducing health inequalities for children and young people](#)

[NHS Lancashire and South Cumbria Integrated Care Board Joint Forward Plan for 2023 onwards](#)

The Soft Drinks Industry Levy Regulations 2018

Tobacco Free Lancashire and South Cumbria Strategy 2023-2028

Oral Health – Roles and responsibilities

The Health and Social Care Act 2012 came substantively into force on 1 April 2013, bringing about a wide range of structural changes that would impact on the NHS, public health and adult social care.

Strategic health authorities (SHAs) and primary care trusts (PCTs) were abolished, with responsibility for NHS commissioning passing to NHS England at a national level and clinical commissioning groups (CCGs) at a local level. Local authorities took over control of health improvement functions and Public Health England (PHE), now the Office for Health Improvement and Disparities (OHID) was established as a national body to oversee health improvement and health protection.

Since April 2013 the roles and responsibilities of Local Authorities, NHS England and OHID in relation to oral health and care are:

Local Authorities have responsibility for improving oral health in the population and there is a Public Health Outcomes Framework (PHOF) measures this by dental decay among five year olds. Local Authorities are therefore responsible for commissioning actions and programmes of work to tackle poor oral health and reduce inequalities. This includes incorporating oral health in commissioned services such as Health Visiting and School Nursing Services.

In addition local authorities are responsible for monitoring general and oral health and undertaking health needs assessments relating to oral health. This responsibility is supported by the OHID Dental Public Health Epidemiology Programme which facilitates national surveys of a variety of population groups and aims to provide estimates of oral health at local authority level. This programme usually requires local authorities to commission local fieldworkers to undertake surveys according to a national protocol. Blackpool Council have commissioned the dental school at the University of Central Lancashire to provide this service.

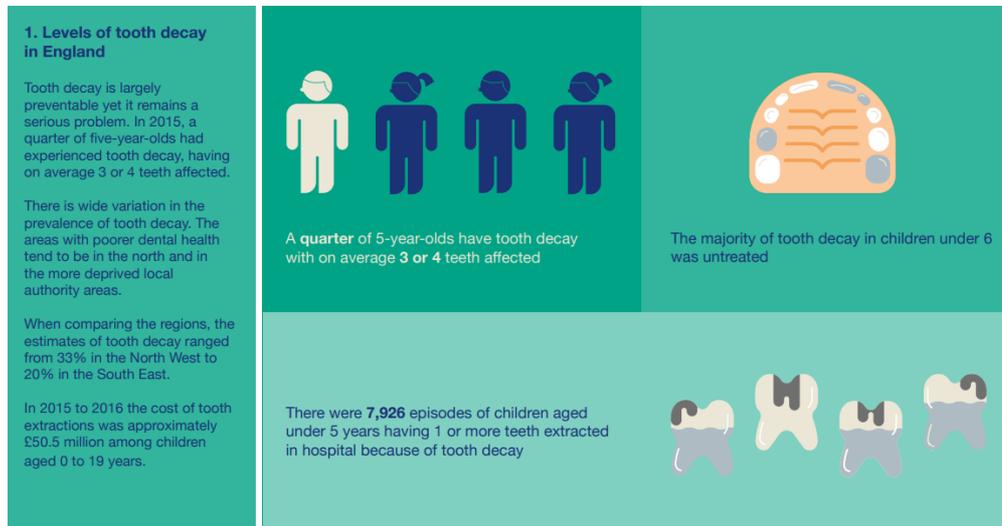
NHS England (NHSE) are responsible for commissioning all primary, specialist and hospital preventive and clinical care for oral conditions. This covers general dental practices, access centres and community dental services for primary care, a range of providers for specialist care and dental and general hospitals for inpatient and outpatient care.

The Office for Health Improvement and Disparities (previously called Public Health England) has a responsibility to provide high level expertise on oral health to support and add value to local authorities and NHS England teams. For example, OHID provides advice to the Lancashire and South Cumbria Oral Health Improvement group.

Background

As with adults, the prevalence of dental caries in children in the UK has reduced dramatically over the past 5 decades. This is generally attributed to the introduction of fluoride-containing toothpaste in the early 1970s. However, other factors such as changed social attitudes, access to dental care, developments in preventive dental materials, and health promoting clinical practices have also contributed to these changes over time. Despite this progress, dental caries, which is largely preventable, remains prevalent and inequalities are marked.¹

Figure 1: Levels of tooth decay in England



Source: PHE, *Health Matters, Levels of tooth decay in England*

The [National Dental Epidemiology Programme for England: oral health survey of 5-year olds 2019](#)² showed:

- 23.4% of 5-year-old children had experience of dental decay
- The average number of teeth with experience of dental decay was 3.4 (5 year old children normally have 20 primary teeth)
- Prevalence of dental decay was higher in children from more deprived areas (34.3%) than in children in less deprived areas (13.7%)
- Children from 'Asian/Asian British' and 'Other Ethnic Group' ethnic groups have significantly higher rates of dental decay than other ethnic groups.

While there has been a decrease in the proportion of children with experience of dental decay from 30.9% in 2008, 27.9% in 2012, 24.8% in 2015 to 23.3% in 2017, there has been no continuing improvement in the results in this latest survey.

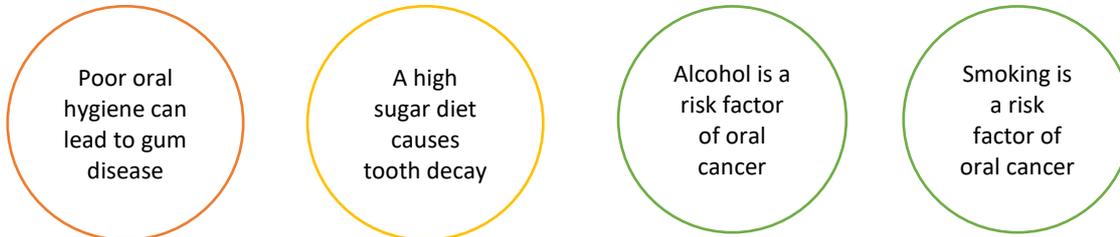
¹ DHSC, Delivering Better Oral Health, [Chapter 4: Dental caries](#), November 2021

² PHE, [National Dental Epidemiology Programme for England: oral health survey of 5-year olds 2019](#) a report on the variations in prevalence and severity of dental decay, March 2020

Diseases affecting the teeth, mouth and surrounding structures

There are a number of modifiable risk factors which can impact on oral health. These risk factors can cause diseases of the mouth:

Risk factors



Tooth decay (dental caries)

Dental caries is one of the most prevalent non-communicable diseases nationally and globally. The disease is caused by too much sugary food and drink and not cleaning teeth and gums properly, or as frequently as recommended. Caries is caused when sugars from our diet are broken down by micro-organisms in the plaque on a tooth surface, which produces acids that, over time, demineralise tooth enamel. The process of de- and re-mineralisation is dynamic. In the early stages of the disease, dental caries can be reversed. However, when factors promoting demineralisation exceed those favouring remineralisation, dental caries progresses (unless checked) into dentine to a point where the tooth surface breaks down and ultimately a cavity forms.

Gum (periodontal) disease

Periodontal diseases are mainly the result of infections and inflammation of the gums and bone that surround and support the teeth. The mouth is full of bacteria; these bacteria, along with mucus and other particles, constantly form a sticky plaque on teeth. Periodontal disease is typically caused by poor brushing and flossing habits that allow the plaque to build up on the teeth and harden.

The first stage of the disease is called gingivitis; the gums can become swollen and red, and they may bleed. This can progress to a more serious form of the disease, called periodontitis, where the supporting bone can be lost, the gums can shrink away from the teeth, and as a result, the teeth may loosen or even fall out. Periodontal disease is mostly seen in adults.

The number and types of treatment will vary, depending on the extent of the gum disease. Physical removal of plaque is the important element of toothbrushing for preventing or controlling periodontal diseases. Therefore, self-care is important to maintain healthy gums and managing gingivitis. More advanced periodontal disease may require dental treatment alongside improved self-care.

Oral cancer

Mouth cancer, also known as oral cancer, is where a tumour develops in a part of the mouth. It may be on the surface of the tongue, the inside of the cheeks, the roof of the mouth (palate), the lips or gums. Tumours can also develop in the glands that produce saliva, the tonsils at the back of the mouth, and the part of the throat connecting your mouth to your windpipe (pharynx). However, these are less common.

Factors which increase the risk of developing mouth cancer include: smoking or using tobacco in other ways, such as chewing tobacco; drinking alcohol; and infection with the Human papillomavirus (HPV).

Access to dental services

The [GP Patient Survey](#) is an independent survey run by NHS England to show how people feel about their GP practice. In Jan-April 2021 2,348 Blackpool patients gave their views on NHS dentistry as part of the GP Patient Survey.

Participants were asked if they had tried to obtain an appointment with an NHS dentist and, if so, whether it was with a practice they had been to before and if they had been successful. They were also asked what their overall experience was of NHS dentistry. Patients who hadn't tried to obtain an NHS dentist in the previous two years were asked to select the main reason why they hadn't tried.

- Of all Blackpool respondents asked, 56% have tried to get an NHS dental appointment in the last 2 years
- Of those who tried to get an appointment in the last two years;
 - 68% were successful in getting an appointment, a success rate of 70% when excluding the 'can't remember' category. This is significantly lower than the national average of 77% and significantly lower than last year's rate of 91%.
 - Respondents who had not been to the practice before were less successful in getting an NHS dental appointment. Younger adults and ethnic minorities also reported a slightly lower success rate.
- The remaining two fifths (44%) did not try to get an appointment with an NHS dentist in the last two years; 26% had never tried to get an NHS appointment and 18% had tried but over two years ago.
- Of those who had not tried to get an appointment:
 - 26% mentioned private dentistry as the reason for not trying to get an NHS appointment; 17% prefer private dentistry and 9% stayed when their dentist moved from NHS to private.
 - Just over a fifth (23%) of those patients who did not try stated they had "not needed to visit the dentist" as the reason for not attending.
 - 13% of the respondents who didn't try to get an NHS dental appointment gave their reason as "I didn't think I could get an NHS dental appointment".

Access to NHS dentistry has been one of the most significant issues raised with [Healthwatch](#) by the public over the last 18 months. Not only have they seen a large increase in the volume of feedback and a significant increase in the amount of negative sentiment, more strikingly, they have noted a continuation of this new trend over time. These issues are not occurring in isolated pockets, people are raising them right across the country.³

[Healthwatch Blackpool](#) received over 70 calls in 2020/21 relating to access to NHS dentistry. Their report⁴ into the issue found that of the 11 dental practices they called in Blackpool

- All stated they were not currently accepting new NHS patients
- 73% stated they were carrying out routine appointments for registered patients only, but 38% of these were prioritising emergency care or offering a limited service
- There was inconsistent advice about how to access NHS dentistry
- A lack of awareness from public and professionals of where people should go to address these issues.

³ Healthwatch, [Lack of NHS dental appointments widens health inequalities](#), May 2022

⁴ Healthwatch Blackpool, Dental Access in Blackpool (January 2021)

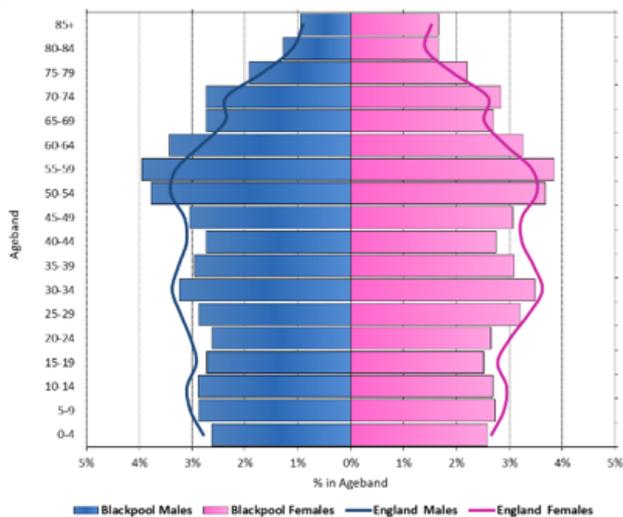
The Blackpool situation

Demographics

The resident population of Blackpool is approximately 141,100. Census 2021 population estimates show that older adults (50 years plus) account for a greater proportion of Blackpool's resident population than is observed at national level. Blackpool's population pyramid shows the higher proportion of people over 50 years of age compared to England, and the much lower proportion in ages younger than 50. The age bands 20-44, in particular, have a considerably lower proportion than England.

England.

Figure 2: Census 2021 Population Estimates



	Blackpool		England
All ages	141,100		56,490,060
0-19	30,520	21.6%	23.1%
20-49	50,375	35.7%	39.1%
50-64	30,950	21.9%	19.4%
65+	29,185	20.7%	18.4%

Source: ONS Census 2021 Population Estimates

Blackpool's population is projected to rise slightly over the next ten years with the main increases being in those aged 65+.

Population turnover (transience) has been identified as an issue in Blackpool with some areas having very high levels of population inflow and outflow. One of the main types of household within Blackpool is single people privately renting low cost rooms for the short term⁵.

The health of people in Blackpool is generally worse than the England average. Blackpool is the most deprived local authority in England and approximately 26.2% (6,855) of children are living in low income families. Life expectancy for both men and women is the lowest in England. There is wide variation within Blackpool, and life expectancy is 12.3 years lower for men and 10.1 years lower for women in the most deprived areas compared to the least deprived areas.

More detailed demographics are available at Blackpool JSNA, [Blackpool Profile](#)

⁵ Blackpool JSNA, [Population Profile](#)

Chapter 1: Start Well

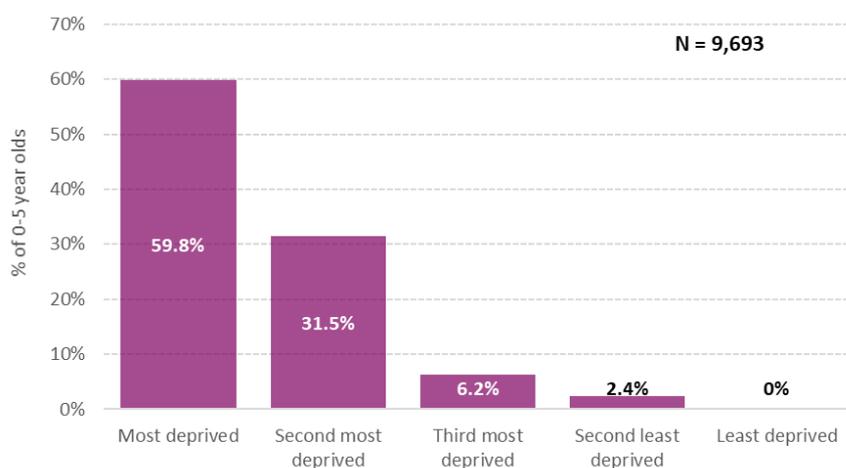
Oral health of children

The oral health of children living in Blackpool remains a concern, with levels of tooth decay in children aged 3 years, 5 years and 12 years old significantly worse than the national average. As with other non-communicable diseases, tooth decay is associated with deprivation.

Data from the National Dental Epidemiology Programme showed the prevalence of dental decay was 13.7% in 5-year-olds living in the least deprived areas compared with 34.3% in those living in the most deprived areas.⁶ Tooth decay is also the number one reason for childhood hospital admissions for general anaesthesia in the UK.

Almost two thirds (60%) of all 0-5 year olds in Blackpool live in the 20% most deprived areas in the country, and none live in the least deprived areas (Figure 3).

Figure 3: Proportion of 0-5 year olds in Blackpool by IMD Decile

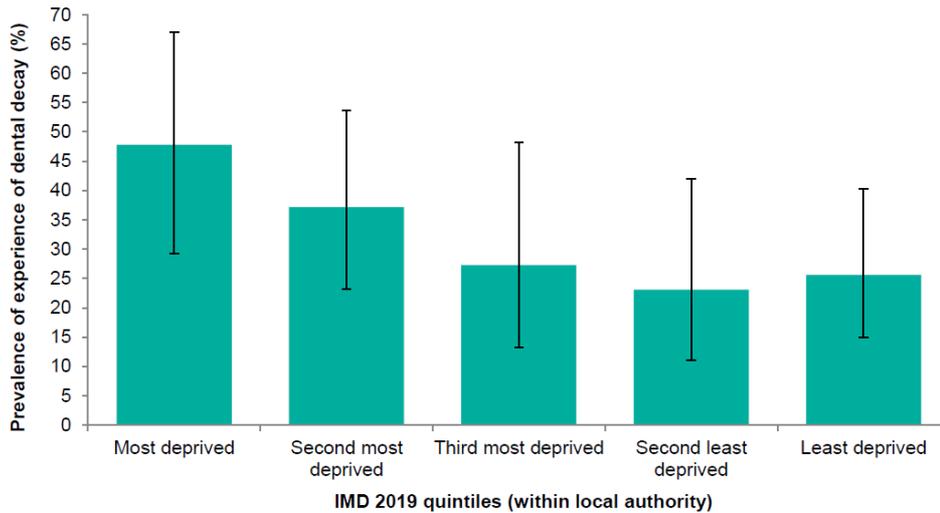


Source: ONS LSOA population estimates, 2020 and IMD 2019

Figure 4 shows the experience of dental decay of 5-year olds in Blackpool by IMD quintile within the town. It clearly shows a socioeconomic gradient in tooth decay between those children living in the most and least disadvantaged parts of town; those children in the more affluent areas have similar levels of tooth decay to the national average (and it must be remembered that nationally, none of Blackpool's children live in the least disadvantaged quintile).

⁶ PHE, [National Dental Epidemiology Programme for England: oral health survey of 5-year-olds 2019](#), A report on the variations in prevalence and severity of dental decay, March 2020

Figure 4: Prevalence of the experience of dental decay in 5-year olds by IMD quintile within Blackpool, 2018/19



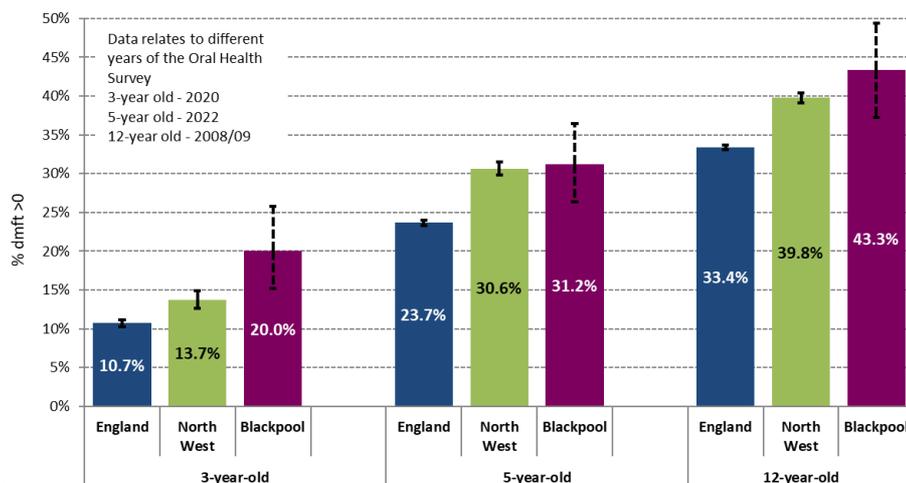
Source: PHE, Oral health profile, Blackpool, April 2021

Although improvements in child health have been made, tooth decay remains one of the most common diseases of childhood affecting physical and psychological wellbeing and quality of life.

Data from the National Dental Epidemiology Programme shows:

- 20% of Blackpool's 3 year olds were affected by visually obvious dental decay in 2019/20, an increase of 3.1% from 2012/13 and significantly higher than the England average of 10.7%
- 31.2% of Blackpool's 5 year olds were affected by visually obvious dental decay in 2021/22, a decrease of 2.2% from 2018/19 and significantly higher than the England average of 23.7%
- 43% of Blackpool's 12 year olds were affected by dental decay in 2008/09 (last recorded data point), significantly higher than the England average of 33.4%
- The average number of decayed, missing or filled teeth in 5 year olds in Blackpool is 1, higher than the national average of 0.8
- In all age groups, decayed teeth are more common than missing or filled teeth.

Figure 5: Prevalence of dental decay - the proportion of children affected by dental decay, Blackpool compared to England and the North West

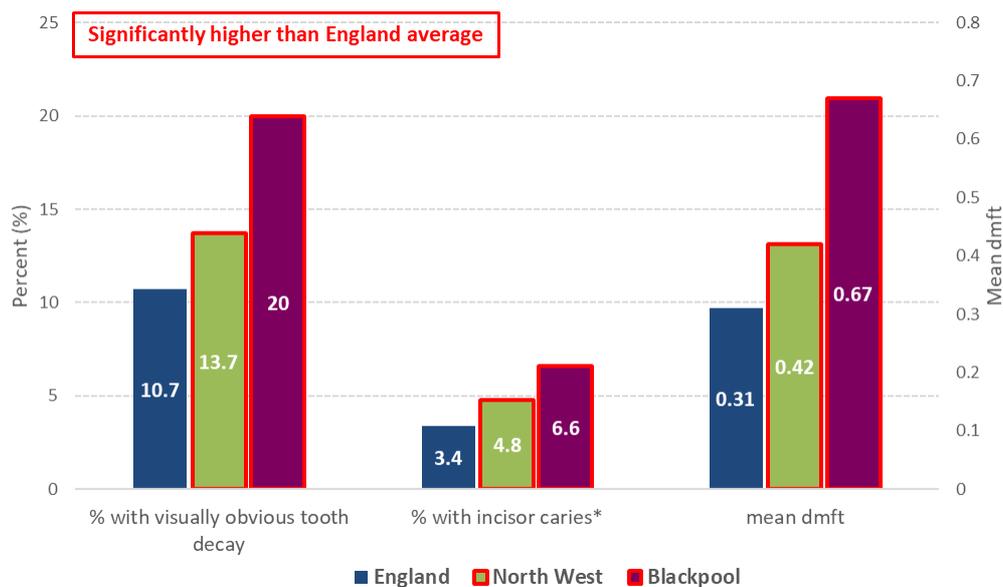


Source: Dental Public Health Epidemiological Programme Oral Health Surveys

Historically there are central government targets for the oral health of five-year-olds, so local government needs to know about decay at ages before age five, so they can work out what sort of interventions are required and what ages they should be targeted towards. It is, therefore, also useful to know the oral health status of three-year-old children.

Results from the last oral health survey of three year old children in Blackpool show that they have significantly more tooth decay than is seen nationally, with the average number of decayed, missing or filled teeth (dmft) twice the national average. Infants' and toddlers' primary teeth can also be affected by an aggressive form of decay called early childhood caries / incisor caries. The disease is associated with the frequent consumption of sugary drinks in baby bottles or sipping cups as it occurs in the upper front teeth and spreads rapidly to other teeth.⁷

Figure 6: Dental experience of three year old children, 2019/20



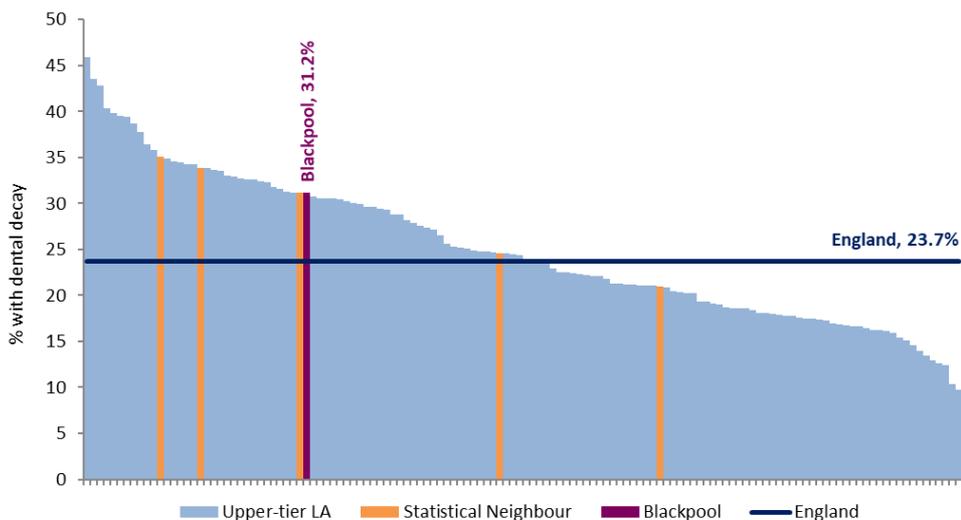
*Incisor caries is an aggressive form of tooth decay that affects upper incisors and can be rapid and extensive in attack.
 Source: OHID, Oral Health Profiles

Oral health is an integral part of overall health; when children are not healthy this affects their ability to learn, thrive and develop. Poor oral health is the most common cause of hospital admission for 6-10 year olds.⁸ The level of dental decay in 5 year old children is a useful indicator of the success of a range of programmes and services that aim to improve the general health and wellbeing of young children. Figure 7 compares Blackpool with all upper tier local authorities in England for the proportion of 5 year olds with experience of visually obvious dental decay. With 31.2% of 5 year olds with dental decay, Blackpool is in the highest quintile (top 20%) for this measure, significantly higher than the England average of 23.6%.

⁷ RCS Faculty of Dental Surgery, The state of children's oral health in England, January 2015

⁸ OHID, Child and Maternal Health Profile, [Oral health](#)

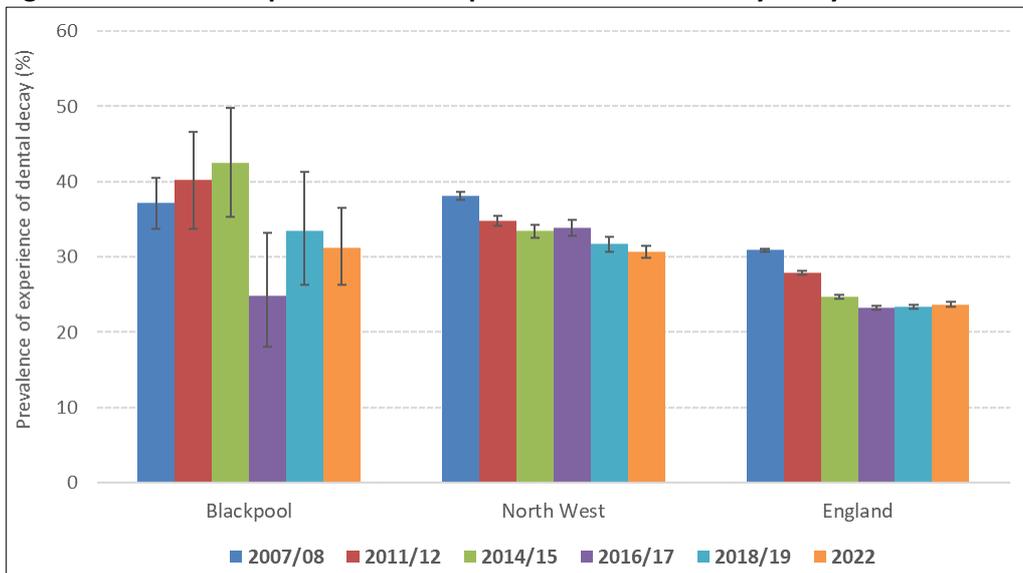
Figure 7: The proportion of children aged 5 years old with experience of visually obvious dental decay, Blackpool compared to upper tier local authorities: 2021/22



Source: OHID, Oral Health Profiles

The prevalence of dental decay in 5-year old children in Blackpool has been significantly worse than the England average for a number of years (with the exception of 2016/17) and while 2021/22 did show a decrease of 2.2% compared to the previous survey, the rate for England increased by 0.3%.

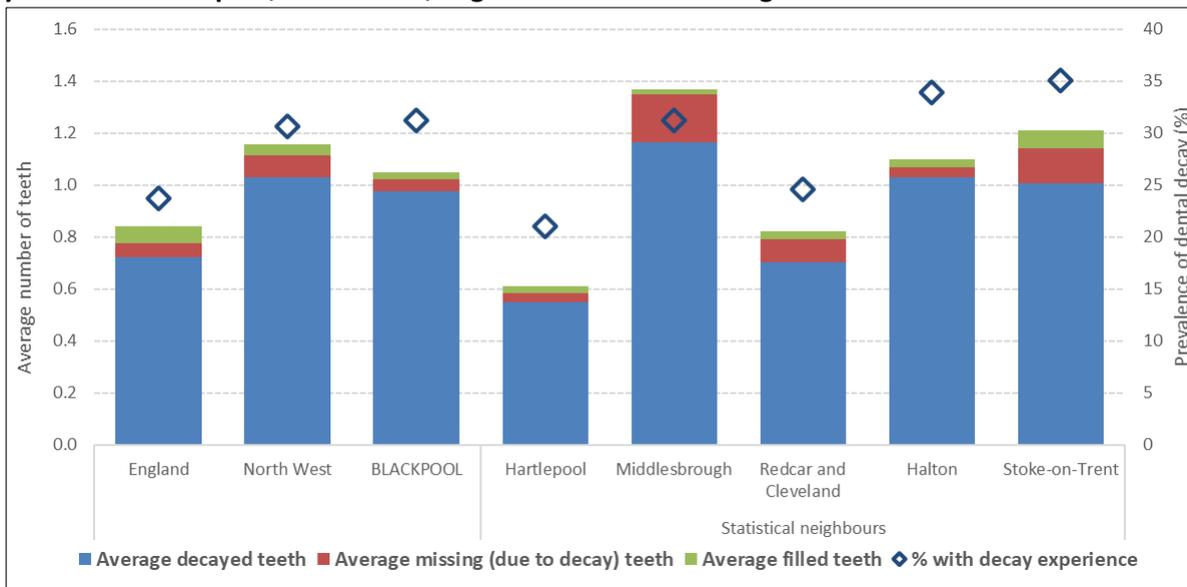
Figure 8: Trend in the prevalence of experience of dental decay in 5-year olds in Blackpool, North West and England



Source: OHID, Oral Health Profiles

The extent to which tooth decay is affecting 5-year olds in Blackpool can be seen in Figure 9. On average Blackpool children have more decayed and missing teeth than the national average and fewer filled teeth suggesting, not only poorer oral health but less access or visits to a dentist for treatment.

Figure 9: Prevalence of experience of dental decay and mean number of teeth with experience of dental decay in 5-year olds in Blackpool, North West, England and statistical neighbours.



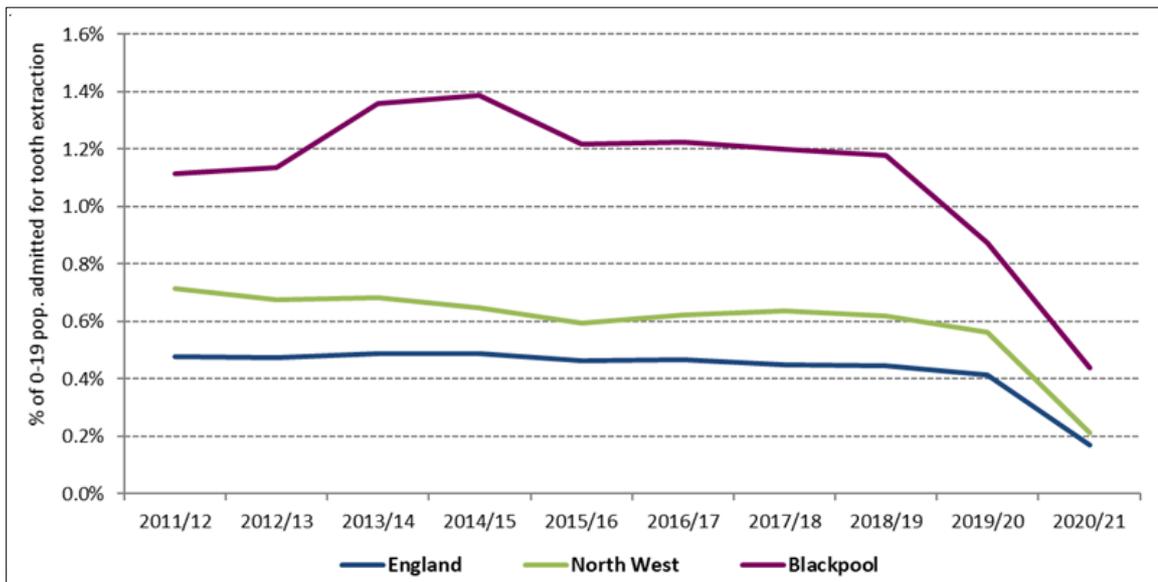
Source: National Dental Epidemiology Programme for England, Oral Health Survey of five-year-old children 2019, Upper-tier local authorities

Tooth decay remains the most common reason for hospital admissions in children aged 6 to 10 years old.⁹ General anaesthetic is often given to children undergoing multiple tooth extractions to reduce pain and anxiety. Dental treatment under general anaesthesia presents a small but real risk of life-threatening complications for children.⁷ Data from the Dental Public Health Intelligence Programme shows that in Blackpool:

- 280 young people aged 0-19 (0.9% of the population) were admitted to hospital for tooth extraction in 2019/20.
- The 2019/20 rate is over two times higher than the national average of 0.4%, though this figure has been reducing.
- 78.6% of Blackpool children admitted to hospital for tooth extraction in 2019/20 were aged under 11 years (Figure 12).
- Children in Blackpool are being admitted to hospital for tooth extraction at a younger age than the national average

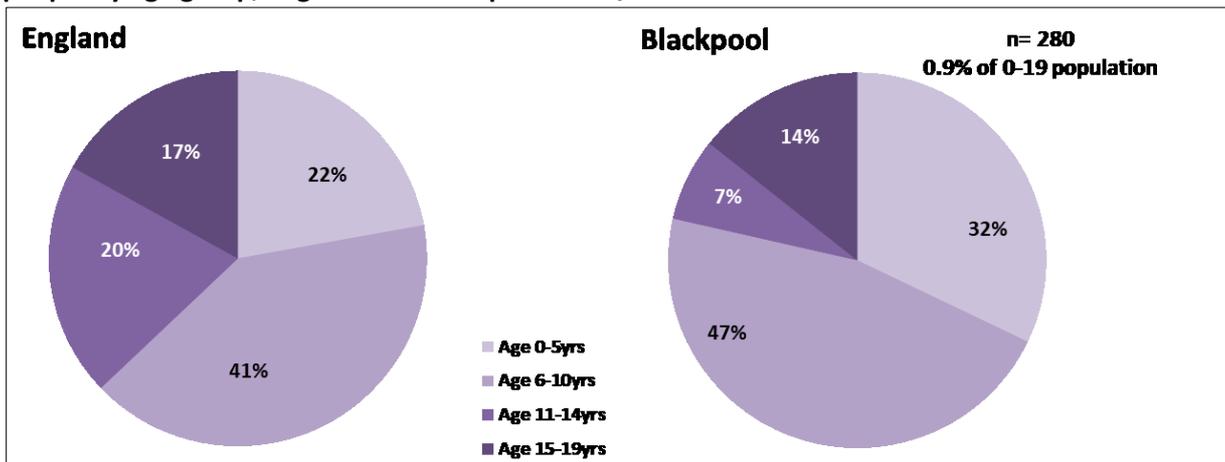
⁹ [Royal College of Surgeons of England, Hospital admissions for 5-9 year olds with tooth decay more than double those for tonsillitis](#), 19 September 2019.

Figure 11: Trend in proportion of 0-19 population admitted to hospital for tooth extraction, Blackpool, North West and England



Source: PHE, Dental Public Health Intelligence Programme, HES Extractions Data 2011/12 - 2019/20

Figure 12: Hospital admissions - proportion of hospital admissions for simple tooth extraction in children and young people by age group, England and Blackpool: 2019/20



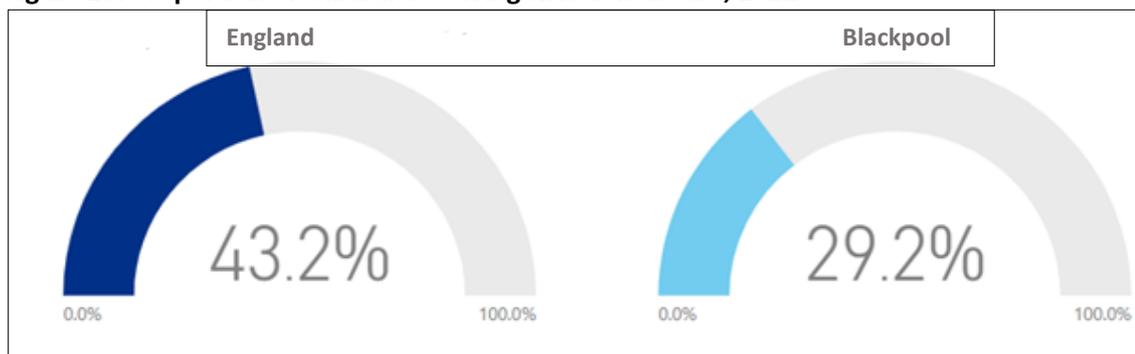
Source: PHE, Dental Public Health Intelligence Programme, HES Extractions Data 2011/12 - 2019/20

Dental services in England are funded either privately or by NHS England. Activity data from NHS primary care dental services is available from [NHS Digital, NHS Dental Statistics](#). Data shows the number of children (age under 18 years) who have received NHS dental care in the previous 12 months.

- Less than a third of Blackpool’s children have been seen by an NHS dentist compared to over 40% across England in 2021
- Figure 14 shows that while the number of children receiving NHS dental care is beginning to recover after the decline due to Covid-19, numbers are not yet back to pre-pandemic levels.
- Data from the Reception age school health questionnaires show that a fifth of Blackpool parents have highlighted a concern for their child’s dental health in 2021.¹⁰

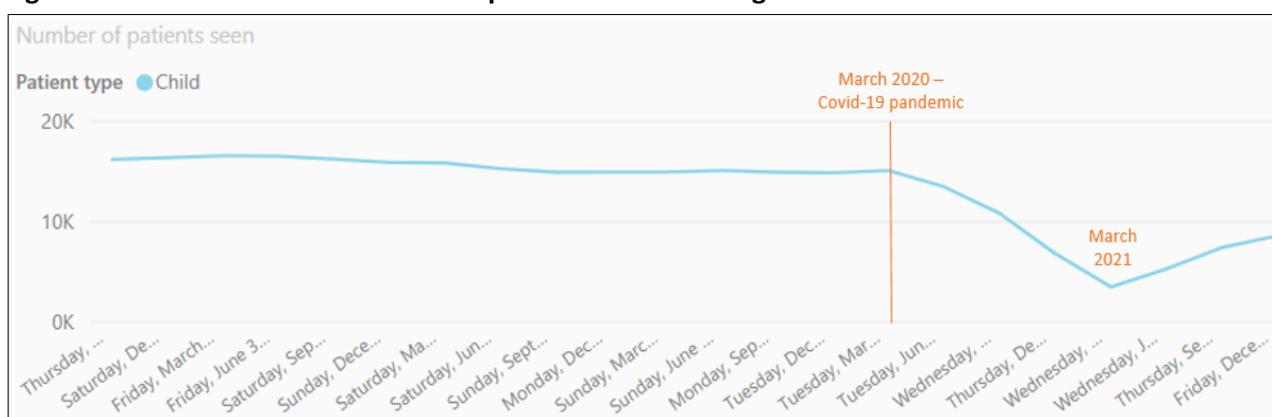
¹⁰ Blackpool Universal School Nursing Service, Reception Health Questionnaires, 2021

Figure 13: Proportion of children receiving NHS dental care, 2021



Source: NHS Digital, [NHS Dental Statistics for England, 2021-22, Biannual Report](#)

Figure 14: Trend in the number of Blackpool children receiving NHS dental care



Source: NHS Digital, [NHS Dental Statistics for England, 2021-22, Biannual Report](#)

Evidence-based population level interventions for children

Evidence of what works for oral health improvement at a population level has been reviewed by the National Institute for Health and Care Excellence (NICE) and PHE¹¹. PHE outline nine population interventions that have evidence that they improve oral health:

- Oral health training for the wider professional workforce
- Integration of oral health into targeted home visits by health/social care workers
- Targeted community-based fluoride varnish programmes
- Targeted provision of toothbrushes and fluoride tooth paste (ie, postal or through health visitors)
- Supervised tooth brushing with fluoride toothpaste in targeted childhood settings
- Healthy food and drink policies in childhood settings
- Fluoridation of the public water supplies
- Targeted peer (lay) support groups/peer oral health workers
- Influencing local and national government policies.

¹¹ Local authorities improving oral health: commissioning better oral health for children and young people (PHE, 2013)

There are a number of oral child health improvement schemes currently in operation in Blackpool:

1. Tooth paste and tooth brush distribution programme (Brushing for Life). All new parents are offered Brushing for Life packs including fluoride toothpaste via the universal checks (6-8 weeks / 12 months / 2-2½ years) delivered by health visitors. The packs are a useful tool for the HV's to broach the subject of oral health and deliver, and re-inforce, key oral health messages.
2. Oral health packs and free flow sippy cups are included in Better Start Engagement packs for expectant / new mums.
3. Weaning / infant feeding service. The service is offered to all new parents, and includes messages on the safest ways to hydrate and feed their babies. This advice helps to protect the child's teeth and diet.
4. Supervised tooth brushing schemes in Primary school reception classes, nurseries and childminder settings.
5. Milk fluoridation scheme. Fluoridated milk is made available to all children in Years 1-6 in Blackpool Primary Schools via the Free School Breakfast initiative.
6. As part of the statutory Health Education in Primary and Secondary schools, students have to be taught about oral hygiene, tooth decay, healthy eating and the importance of regular visits to the dentist.
7. Give Up Loving Pop (GULP) Campaign. A campaign is run across all Year 4 classes in Blackpool Primary schools each year. This comprises of a competition for pupils to swap sugar-sweetened drinks for water for 21 days as a way of changing behaviour.
8. Fit2Go. A six-week healthy lifestyle programme delivered to all Year 4 pupils in Primary schools. Oral health / healthy drinks and snacks are covered within the programme.
9. Junior Healthier Choices Award. The award is achieved when food venues offer a welcoming space for mum's to be able to be able to breastfeed or bottle feed for eat-in venues, and provide free milk or water for infants/young children.
10. Blackpool Together Pilot Programme – NHS England funded initiative to pay for protected time for dentists to see 'families in need' who have children under 5, and any dental treatment required to make them 'orally fit' Better Start manage referrals, liaise with the dental practice, and provide support to families to attend the appointments. Currently, one dental practice has committed a half-day each week to see these children, and their siblings.
11. Every Smile Matters – programme being implemented by Blackpool Teaching Hospitals NHS Foundation Trust (BTH) to ensure that all school-aged children and parents are provided with consistent oral health messages at EVERY health contact.
12. Core20PLUS5 – A national NHS England approach to support the reduction of health inequalities. One of the 5 clinical areas of focus is for Integrated Care Boards to reduce the incidence of children aged 10 years and under admitted as inpatients for tooth extractions.

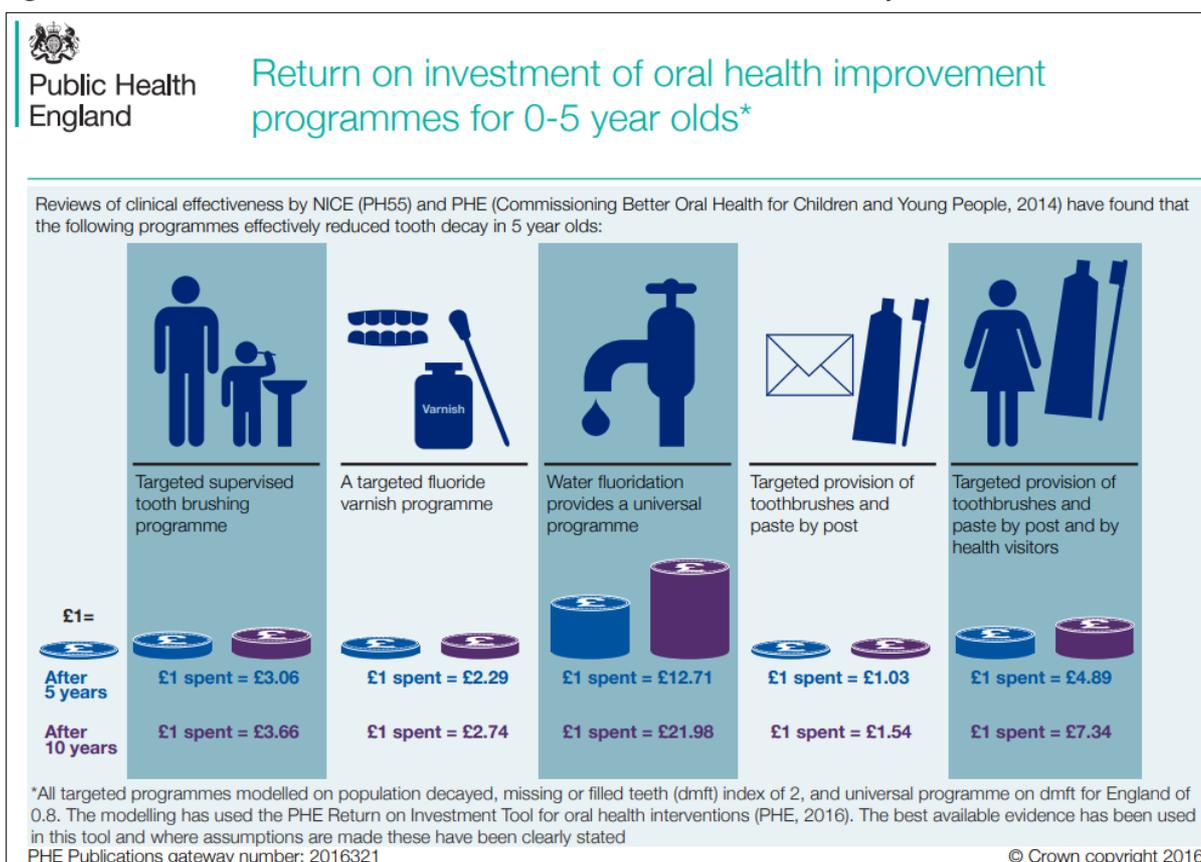
Cost effectiveness of targeted, evidence-based programmes

The benefits of better oral health to individuals and the local community are:

1. Parents not having to take time off work (potentially unpaid) to take their children to the dentist.
2. Improved school attendance due to fewer absences caused by tooth ache or tooth extractions.
3. Better long-term health due to the links between poor oral health in childhood following into adulthood and chronic illness.
4. Improved Public Health Outcomes Framework indicators for the Local Authority.

Figure 15 shows that the supervised brushing programme and provision of toothbrushes and paste by health visitors in Blackpool are cost effective. This is in addition to good evidence of effectiveness in reducing the average number of decayed, missing and filled teeth.

Figure 15: PHE return on investment – reviews of clinical effectiveness by NICE and PHE, 2016



Our recommendations to improve the oral health of children in Blackpool:

Recommendation 1: Ensure all staff working with children in Early Years settings are offered free e-learning training on oral health each year.

Recommendation 2: Public Health and the Blackpool Better Start partnership to recruit an Oral Health Co-ordinator / Trainer to link with dental practices, deliver training and co-ordinate existing oral health prevention programmes.

Recommendation 3: The Blackpool Better Start partnership to develop a parent champion network of local parents who will be trained to pass on friendly oral health advice and support to their peers.

Recommendation 4: Public Health to continue to fund oral health packs for our Health Visitors to distribute to new parents on three visits, and expand the scheme to the Early Parenthood Service to deliver in community settings.

Recommendation 5: Continue to support, and increase the number of, Early Years settings providing supervised brushing programmes.

Recommendation 6: Continue to fund, and increase the uptake of, Primary Schools taking part in the milk fluoridation programme.

Recommendation 7: Explore with NHS England and the Lancashire and South Cumbria Oral Health Improvement group how dental practices can apply fluoride varnish to children in areas with high rates of decay, and make sure that all children are given the opportunity to register with a dentist.

Recommendation 8: Public Health to continue to commission the Give Up Loving Pop (GULP) campaign in Primary schools and extend to Secondary schools and Early Years settings.

Chapter 2 – Live Well

Oral health of adults

The scale of the problem - national and local context

Surveys of oral health in adults within the UK suggest that there are 3 cohorts in the population:

- the oldest age cohort, who have lost all their teeth, and wear complete dentures
- a middle age cohort, who retain most of their teeth, but do so largely because of the efforts of the dental profession who have restored and maintained teeth in those who grew up before fluoride toothpaste became widely available
- the youngest age cohort, many of whom are caries-free in their early years

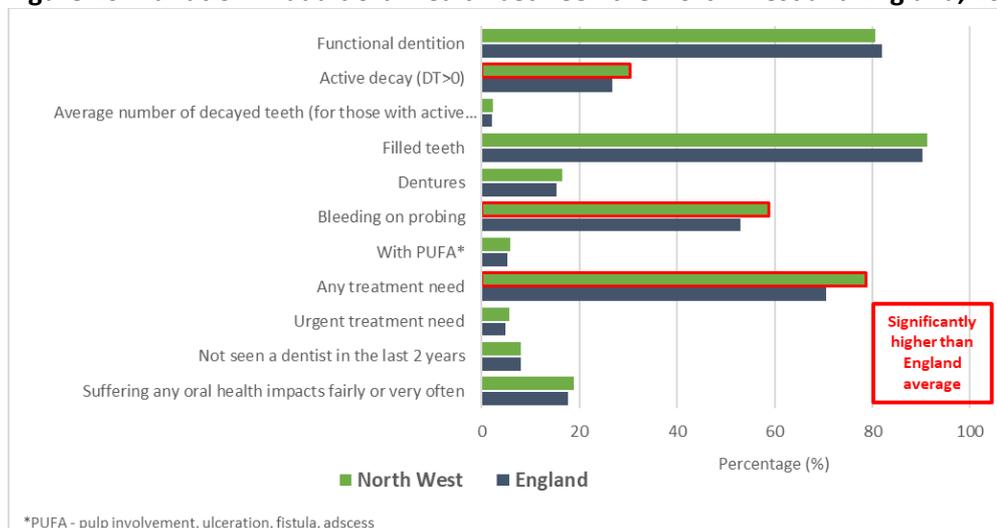
Good oral health is not enjoyed equally across the population in England. The impacts of poor oral health disproportionately affect the vulnerable and socially disadvantaged individuals and groups in society

Adults in routine and manual occupations have higher levels of tooth decay, severe diseases and tooth loss than their counterparts in intermediate occupations. The latter in turn have higher levels of these oral diseases compared to their counterparts in managerial and professional occupations.

Whilst data on the dental health of the adult population of Blackpool is not available, we do know that, as one of the most disadvantaged local authorities, the oral health of the population will be significantly worse than that seen nationally.

Figure 16 shows the variation in oral health between the North West and England, Blackpool will probably show similar, if not worse, rates to the North West.

Figure 16: Variation in adult oral health between the North West and England, 2018

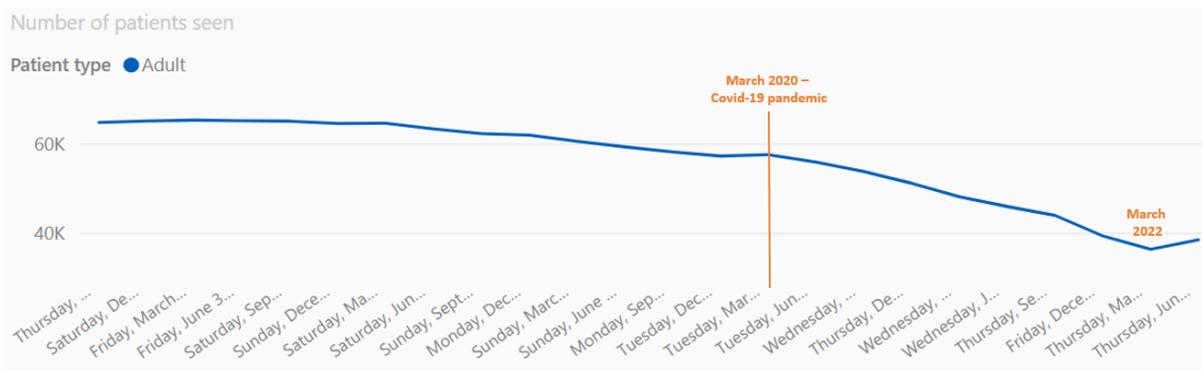


Source: PHE, National Dental Epidemiology Programme for England, 2018

Data from [NHS Digital, NHS Dental Statistics](#) showed that as at June 2022:

- 38,500 adults in Blackpool received NHS dental care in the preceding 24 months
- This is 35% of the population, slightly lower than the proportion receiving dental care across England (37%)
- As with children, there was a steep decline in NHS dental care due to Covid-19, however, unlike children, the numbers receiving care are only just beginning to show an increase and are not back to pre-pandemic levels.

Figure 17: Trend in Blackpool adults receiving NHS dental care in the preceding 24 months

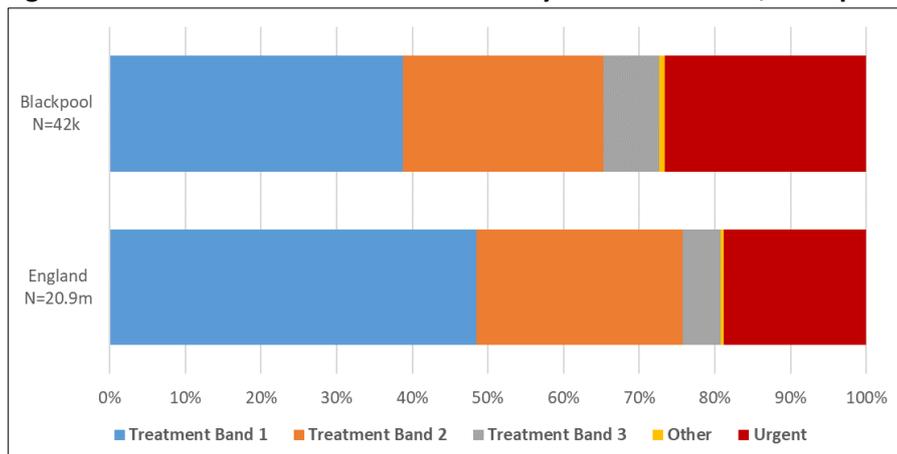


Source: NHS Digital, [NHS Dental Statistics for England, 2021-22, Biannual Report](#)

Figure 18 shows the type of treatment adults receive through NHS dental care.¹² Of the 42,000 courses of treatment received in Blackpool over a 12 month period, more than a quarter (26.6%) were classed as urgent. This compares to less than 20% nationally. Treatment band 3 cases which include treatments such as crowns, dentures and bridges were also higher than is seen nationally. This suggests that when Blackpool residents are accessing NHS dental care their oral health is in a worse state than is seen nationally and therefore they need more complex treatment.

‘Urgent’ treatment is provided where oral health is likely to deteriorate significantly, or the person is in severe pain by reason of their oral condition.

Figure 18: Courses of Treatment delivered by Treatment Band, Blackpool and England, Oct 2020 – Sept 2021



Source: NHS Digital, [NHS Dental Statistics for England, 2021-22, Biannual Report](#)

¹² NHS Digital, [NHS Dental Statistics: Annex 4 - Publication Guidance](#)

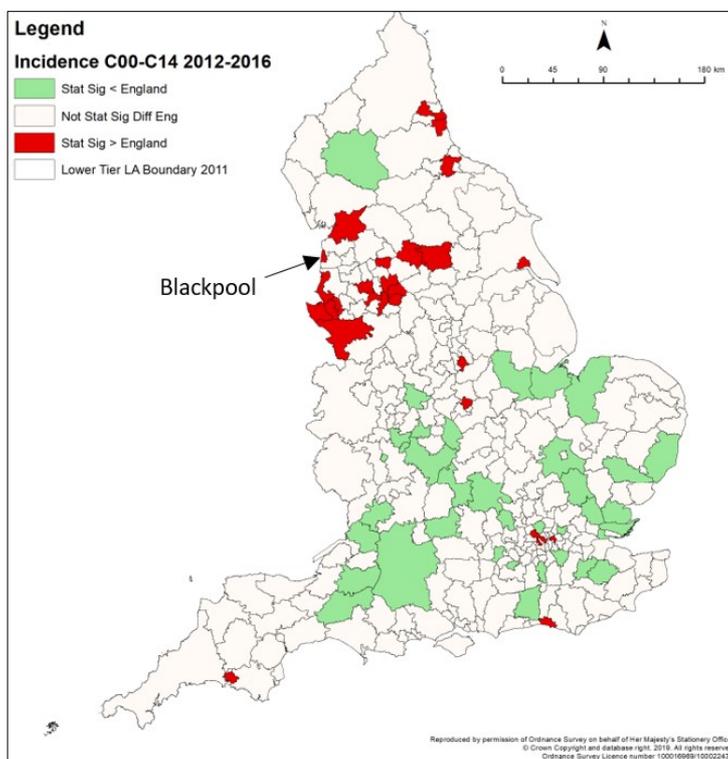
Oral cancer

Oral cancer is the sixth most common cancer worldwide. Approximately 8,300 cases of oral cancer are diagnosed each year in the UK and around 2,300 people die from the disease each year. The leading causes of mouth cancer in the UK are tobacco and alcohol consumption and the incidence and mortality from oral cancer increases with deprivation.

For cancers diagnosed in 2006 to 2010, oral cavity cancer rates in males in the most deprived group were at least double that of the least deprived group. Incidence rates were also significantly higher for the most deprived compared with the least deprived group in females.¹³

- Almost a fifth (19.8%) of Blackpool's population smokes tobacco and this rises to a quarter for those in routine and manual occupations
- Alcohol related hospital admissions and deaths in Blackpool are among the highest in the country
- While numbers of deaths from oral cancer in Blackpool are low (38 in the 3 years 2019-21) data from Public Health England shows that the incidence of oral cancer in Blackpool is significantly higher than the England average.

Figure 19: Standardised incidence of oral cancer (C00-C14) 2012-2016 by local authorities in England



Source: PHE, *Inequalities in oral health in England*, 2021

¹³ PHE, National Cancer Intelligence Network, Cancer and equality groups: key metrics 2015 report, July 2015

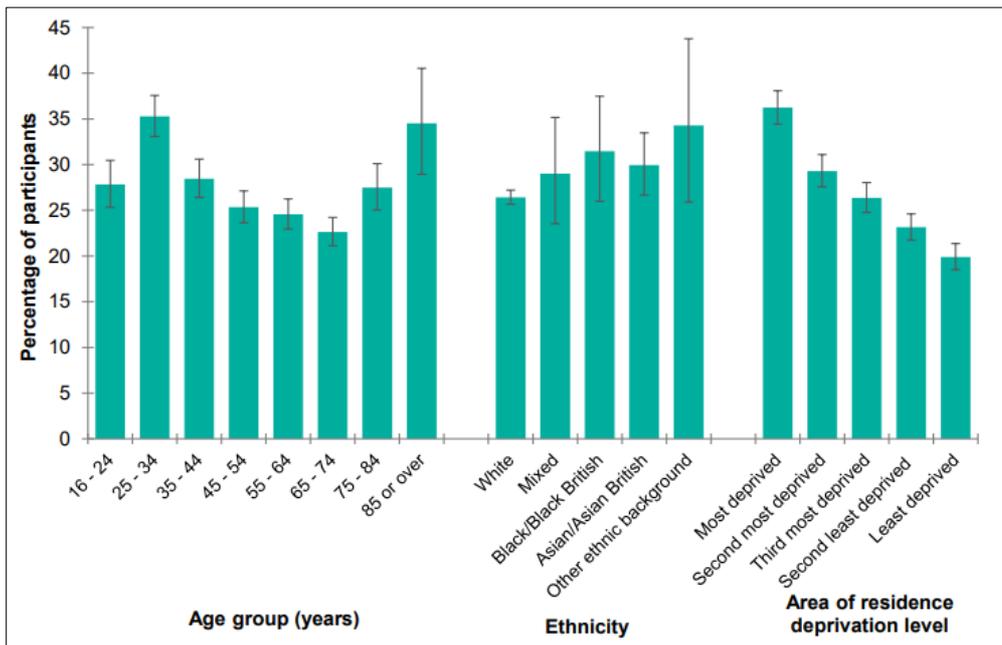
While oral health in England has improved significantly across the population as a whole over recent decades there are still marked inequalities. The [adult oral health survey 2018](#)¹⁴ reported that across England:

- only 1% of adult dental attendees had none of their own teeth
- 82% had 'functional dentitions' (21 or more natural teeth)
- 90% had at least one filling
- 47% had crowned teeth
- 71% were assessed as having a current need for dental treatment
- 27% had tooth decay, having on average 2.1 decayed teeth
- 53% had gingival (gum) bleeding
- 18% reported currently being in pain.

Poorer oral health disproportionately affects older people and those from more deprived areas. Around two-thirds of participants aged 85-years and older did not have a functional dentition. One in 3 participants living in the more deprived areas of England had untreated tooth decay compared to 1 in 5 in the less deprived areas. Reports of impacts from oral problems in the last year in participants living in more deprived areas were almost triple those of participants living in less deprived areas (28% versus 11%).¹⁴

What is not known from the adult oral health survey is if this picture of oral health needs in adult dental attendees is markedly different from the general population. Participants in the survey could have better oral health than the general public, as for the most part these were people reporting to be regular dental attendees with the benefit of professional support for maintaining their oral health. On the other hand, these were people surveyed when attending a dental appointment where the prevalence of a dental problem could be higher as they were seeking professional care. Contemporary information about whether people go to the dentist for check-ups or only when there is a problem is lacking, but there were suggestions in the last decennial survey of adult oral health of an increasing pattern of seeking care only when there was a dental problem. This survey may also underrepresent a proportion of the general public for whom attending the dentist is unaffordable.¹⁴

Figure 20: Percentage of adult survey participants with one or more decayed and untreated teeth, by age group, ethnicity and deprivation



Source: PHE, National Dental Epidemiology Programme for England: Oral health survey of adults attending general dental practices 2018

Overall, this survey of dental attendees in England paints a picture of a population where virtually all adults have at least some natural teeth but where impacts and signs of dental disease are prevalent. The survey highlights that the effects of poorer oral health disproportionately affect some parts of this population, most notably older people and those living in the more deprived areas of England.¹⁴

Adult groups prone to poor oral health

PHE have compiled a report on [Inequalities in oral health in England](#). Overall, the available evidence suggests high levels of need among vulnerable populations.

People with Learning Disabilities

PHE identified several individual and organisational barriers for people with disabilities in their report. These being:

Individual barriers:

- Inability to tolerate treatment
- Lack of knowledge of accessing oral healthcare services
- Lack of social support

Organisational barriers:

- Difficulties in finding a dentist willing to provide treatment
- Shortage of dentists with adequate knowledge, training and confidence in caring for people with disabilities
- Lack of perceived need for training
- Lack of awareness of legal responsibilities as service providers towards overcoming barriers
- Communication barriers

- Poor patient management skills and perceived negative attitudes of dental staff
- Dental professionals perceive the additional time and effort required to treat patients is not fairly compensated by the remuneration system
- Lack of availability of domiciliary equipment
- Lack of information on oral health and oral healthcare services in the appropriate format
- Physical barriers to accessing dental services such as finding suitable transport along with the lack of availability of accessible waiting areas and toilet facilities
- Oral health knowledge and oral health beliefs of carers and their expectations of dentists
- Oral health perceived as a low priority among other health problems
- Lack of continuity of care and a lack of collaboration between and within

These lead people with disabilities to experience inequalities accessing services, experiencing caries and tooth loss and trauma induced dental injury.

The Homeless

Homeless people tend to experience very poor health¹⁵. There are high incidences of physical illness, mental-health problems and substance misuse among the homeless population. These forms of ill health often combine with each other, and are both causes and consequences of homelessness.

Research shows high levels of oral and dental disease among homeless people, both in absolute terms and relative to the rest of the population. This is attributable to the following risk factors:

- Chaotic lifestyle, with no established routines of eating and oral hygiene
- Low priority given to healthy eating and oral hygiene
- Acceptance of poor dental health and poor dental appearance as the norm
- Limited access to hygiene facilities
- Low disposable income
- Inability to have a healthy diet and maintain oral hygiene
- Mental-health problems
- Substance misuse
- Stigma accessing healthcare services

The main clinical conditions encountered among homeless people are:

- caries (decay), particularly around the necks of teeth
- deep periodontal (gum) disease
- trauma (damage due to accidents or violence)
- a need for dentures

¹⁵ 'The dental health of homeless people' – British Dental Association

- broken or ill-fitting dentures
- soft tissue conditions - mostly infections but also cancerous, or potentially precancerous, lesions

For this particular service group, a more flexible approach is required especially in regards to any dental appointments. Appointments with consequences of no attendance (such as being removed from the service or an 'opt-in' system) act as a deterrent for accessing future treatment, as does perceived stigma and stereotyping from professionals/services. Frequently there is non-attendance from individuals for a variety of reasons e.g. the service user did not have the means to attend the appointment be this due to lack of transport, the cost of transport, because the distance is too far to the clinic or because the service user forgot about the appointment because of their chaotic lifestyle.

When discussing their oral hygiene, the homeless population also mention a lack of self-confidence and self-esteem. This often leads people to believe they are not 'worthy' of treatment and so they feel they have no choice but to accept this.

Substance misuse

Many drugs can cause a craving for sugar, such as sweets and fizzy drinks, which can cause tooth decay.

Drugs such as Methamphetamine and Heroin can also cause you to have a dry mouth. Because there is a reduced saliva flow in the mouth, this can also lead to tooth decay and gum disease.

Some drugs, such as Ecstasy and Cocaine can lead to jaw-clenching and tooth grinding. This can result in cracked or broken teeth, as well as headaches and jaw pain.

Alcoholic drinks such as white wine, beer and cider can be very acidic. This will cause erosion of the enamel on the teeth, possibly leading to pain and sensitivity. Mouth cancer is also at increased risk by some of the above behaviours, and dentists now routinely screen their patients. More so if they admit to the above, to detect mouth cancer early.

Our recommendations to improve the oral health of vulnerable adults in Blackpool:

Recommendation 9: Work with NHS England and the Lancashire and South Cumbria Oral Health Improvement group to improve access to NHS dental practices.

Recommendation 10: All services working with adults with substance misuse issues, homelessness and learning disabilities to be provided with access to free oral health [e-learning](#) for practitioners.

Recommendation 11: L&SC ICB and Fylde Coast Medical Services to carry out a three month pilot project with the homeless community to undertake dental assessments and treatments. Outcomes to be used to build a business case for further funding for a permanent service in the future.

Recommendation 12: Public Health to work with the Council's Learning Disability team to identify 'Blackpool-specific' individual and organisational barriers to people living with learning disabilities and developmental conditions accessing oral health information and services. Identify and implement solutions where possible.

Chapter 3 - Age Well

Vulnerable older adults in care homes or who receive care at home

There are currently 11 million people in the UK over the age of 65, a figure that is set to increase to 14 million by 2032 (PHE, 2015). Estimates indicate that older people (65 years plus) account for a greater proportion of Blackpool's resident population than is observed nationally. Since the 2011 census there has been a 7.6% increase in the number of people aged 65 and over in Blackpool, compared to a national increase of 3.6%. There are an estimated 29,300 people aged 65 years and above resident in Blackpool (ONS, Census 2021). Projections of the population of Blackpool indicate that the number of residents over 65 will show a considerable increase within the next 25 years, far in excess of the levels of increase shown in all other age bands. The over 65 population was projected to rise by 24% from 28,400 in 2018 to almost 36,000 in 2039 and will then make up over a quarter (26%) of Blackpool's total population (ONS 2018-based subnational population projections).

Good oral health is an essential part of active ageing (WHO, 2002). Ensuring that people can participate in social life free from embarrassment or pain and continue to enjoy a balanced and nutritious diet, contributes hugely to quality of life and general health. Malnutrition is a particular problem among the elderly, with 1.3 million of the 3 million people affected in the UK over the age of 65 (AgeUK, 2015). Any restrictions placed on the variety of foods that an individual is able to eat, such as painful or loose teeth or dentures may contribute to deteriorating nutritional status. Older people with good oral health can eat and drink properly and actively take part in life. This means that they can often stay independent longer and can recover from episodes of frailty more quickly.

Long-term conditions can limit older people's ability to carry out their usual daily activities, which may impact on their oral hygiene routine and diet. This can leave older people at higher risk of both dental caries and periodontal disease. The majority of adults aged over 75 are limited in their daily activities and the proportion who experience limitations has increased through the 1991, 2001 and 2011 censuses (National Audit Office, 2014). Manual dexterity and tooth-brushing ability may be compromised by arthritis, Parkinson's disease and dementia, which can exacerbate periodontal disease and lead to tooth loss. Diabetes is also known to increase the risk of periodontal disease and hasten its progression (Taylor and Borgnakke, 2008). Older people living in care homes are, however, more likely to have experienced tooth decay and the majority of residents with one or more natural teeth will have untreated tooth decay (PHE, 2015). The Care Quality Commission (CQC) 2019 review indicated that too many people living in care homes are not being supported to maintain and improve their oral health. All care providers have an essential role in assessment, care planning and ensuring good daily mouth care.

OHID has a [toolkit](#) for care homes to help with the implementation of NICE guidelines for improving the oral health of adults in care homes. [E-learning](#) is available free for all staff across the North West of England. It contains training material suitable for the wider care team, including the responsibilities of care managers and the role of care staff carrying out admissions, assessments and provision of daily mouth care.

Our recommendations to improve the oral health of vulnerable adults in Blackpool care homes or who receive care at home:

Recommendation 13: Every person's oral health should be assessed as part of the holistic assessment of needs and personalised care and support planning process in care homes / domiciliary care.

Recommendation 14: Care homes should have an oral health policy in place with at least one staff member taking responsibility for this policy within the home. This should be clearly aligned to [NICE guidance 48 Oral Health for Adults in Care Homes](#).

Recommendation 15: Every person's oral health should be enquired after and/or observed regularly by care home staff as part of their usual hygiene routine, and they should have access to routine dental checks and specialist dental professionals as appropriate. Local systems should work collaboratively to provide access to appropriate clinical dental services for people living in care homes.

Recommendation 16: Staff employed by care home providers should undertake training in oral healthcare to support delivery of oral health assessments and daily mouth care for individuals, and maintain this knowledge and skill through ongoing professional development.

Recommendation 17: Adult Social Care to encourage [oral health e-learning](#) for **all** staff working in care homes or who support our vulnerable elderly residents who live in their own homes. This should take place on induction and as annual refresher training.

Our recommendations to improve the oral health of residents of all ages in Blackpool:

Recommendation 18: Co-produce and deliver targeted communications campaigns with residents and partners to promote good oral health.

Recommendation 19: Publish the Dental Helpline telephone number in Your Blackpool on a regular basis to inform residents how to access emergency dental treatment and information on how to register with an NHS General Dental Practice.

Action Plan

A separate Action Plan document has been produced to ensure that the recommendations are implemented.

Guidance / References

[Local authorities improving oral health: commissioning better oral health for children and young people An evidence-informed toolkit for local authorities](#)

[Oral health: local authorities and partners - Public health guideline \[PH55\]](#)

[Oral health for adults in care homes - NICE guideline \[NG48\] Published: 05 July 2016](#)

[Delivering better oral health: an evidence-based toolkit for prevention](#)

[Inequalities in oral health in England \(Mar 2021\)](#)

[Oral health survey of adults attending general dental practices 2018](#)

[Smiling matters: Oral health care in care homes – CQC Review 2019](#)

[What is Known About the Oral Health of Older People in England and Wales: A review of oral health surveys of older people – Public Health England \(2015\)](#)

[A quick guide to a healthy mouth in adults – Public Health England \(2016\)](#)