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7 Oral health

7.1 Introduction

Oral health is defined by the World Health Organization as: [1]

> *"A state of being free from mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum) disease, tooth decay, tooth loss, and other diseases and disorders that limit an individual's capacity in biting, chewing, smiling, and speaking, along with their psychosocial wellbeing."*

Oral conditions cover diseases of the mouth, teeth, and gums. These conditions are a significant cause of ill health. The Global Burden of Disease Study estimates that these conditions contribute a total of 476 per 100,000 years of life lived with disability in the UK, with most of this coming from serious tooth loss. [2]

Oral health also includes cancers that can develop in parts of the mouth such as the lips, gums, throat and tongue. These are uncommon and less significant in terms of overall public health burden than other oral disease. However, oral cancers are estimated to cause a further 4.8 per 100,000 years of life lived with disability nationally and to cause 5.2 deaths per 100,000 people. It is important to note that many cases of oral cancer are caused by the human papillomavirus (HPV) – as such they have the potential to be prevented by the existing vaccination programme, which targets girls aged from 12 to 18. There is also a current trial offering the HPV vaccine to men who have sex with men (MSM). [3]

Poor oral health can mean pain and discomfort; it can affect how a person expresses themselves and they may limit their smiling, talking or laughing. They may also restrict their food choices and have less pleasure in eating food. Conversely, good oral health can contribute to general wellbeing and enjoyment of life. [4]

Oral health is also a significant source of health inequality. In particular, oral health is often worse among males and older people, among socio-economically deprived populations, and among some people with disabilities (see Section 7.4).

There are limited data available on adults' oral health at a local level – in this section, where appropriate, regional or national data are used instead. Where data are not recent, they can still be considered indicative of general patterns.

For information on children and young people's oral health, see the 'Children and young people' chapter of the JSNA.

Box 1: Definitions used in this section

Gum disease (gingivitis) – a very common condition in adults where bacteria cause the gums to become swollen, bleeding and sore. If left untreated, gums can recede, and it can lead to complications such as abscesses and tooth loss.

NHS treatment band – an indication of the type of NHS dental treatment received, ranging from Band 1 (prevention and diagnosis) to Band 3 (complex procedures). For more information, see Table 1.

Oral cancer – cancers affecting the lips and oral cavity, as well as the upper and lower parts of the throat (or pharynx).

Tooth decay (dental caries) – the breakdown of teeth due to acid produced by bacteria that live in the mouth. Symptoms can include pain, tooth discolouration and bad breath. [5] It can result in holes in the teeth.

Table 1: NHS treatment bands

Treatment band	Type of treatment	Includes	Cost to patient* (April 2018)
Band 1	Prevention and diagnosis	Examination, diagnosis, advice. May include X-rays, a scale and polish, planning for further treatment	£21.60
Band 2	Core procedures	Fillings, root canal, extractions	£59.10
Band 3	More complex procedures	Crowns, dentures, bridges	£256.50
Urgent	When urgent care is required	All urgent treatment needed	£21.60 for emergency visit; further charges possible for follow-up treatment

Source: NHS Choices. [6]
*Note: Not all patients have to pay for NHS dental treatment. [7]

7.2 Causes and risk factors

Poor oral health is strongly linked to sugar consumption and other dietary factors, as well as poor oral hygiene. Smoking, chewing tobacco (or betel nuts) and alcohol are also risk factors for poor oral health. [8] It should be noted that these risk factors are shared with major chronic diseases such as cardiovascular disease, cancer, respiratory disease and diabetes (covered by other sections of this JSNA chapter).

For further information on smoking, alcohol and dietary population health needs in Hackney and the City, see the ‘Lifestyle and behaviour’ chapter of the JSNA.

Higher rates of poor oral health (in adults) are observed in socio-economically deprived populations, among males, and among some people with disabilities.

These groups are generally more likely to have one or more risk factor for poor oral health, and are less likely to undertake preventative actions or access services regularly.

Older people have a higher rate of long-term health conditions that may affect their oral health routines and diet, along with a longer time available to accumulate caries, and increased barriers to services.

See Section 7.4 for a more detailed description of inequalities in oral health.

People with a family history of poor oral health are also considered to be at higher risk. [9]

HPV is also a risk factor for some oral cancers. For further information on the prevention of HPV, see the 'Cancer' section of this chapter of the JSNA.

7.3 Local data and unmet need

7.3.1 Numbers affected – use of dental services

In the two-year period covering April 2015 to March 2017, 89,786 adult Hackney residents and 1,484 adult City residents were seen by NHS dentists somewhere in England. [10] Each patient is counted only once even if they have received several episodes of care over the two-year period.

No data are available for private dental treatment.

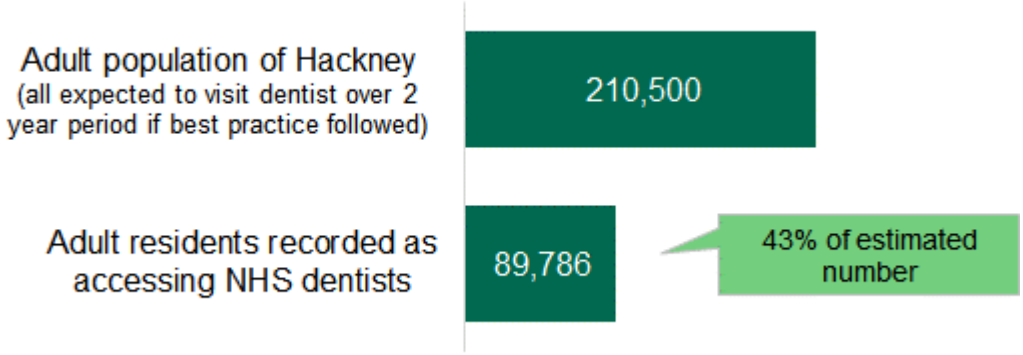
Over the period 2013–15, there were 64 cases of oral cancer recorded in residents of Hackney and the City of London.

7.3.2 Unmet need

It is recommended that all adults should visit the dentist at least once every two years, although the interval between oral health reviews should be determined individually for each patient and may be much shorter. [11]

This means that over a two-year period the entire adult population should visit the dentist. In Hackney, this would be 210,500 people; in the City of London, this would be 6,300 people. [12]
Figure 1 suggests that only 43% of adult residents of Hackney are receiving NHS dental treatment with the recommended frequency. However, this estimate does not take into account those who receive private dental care or travel outside England for their dental care (although for the latter, numbers will be very small).

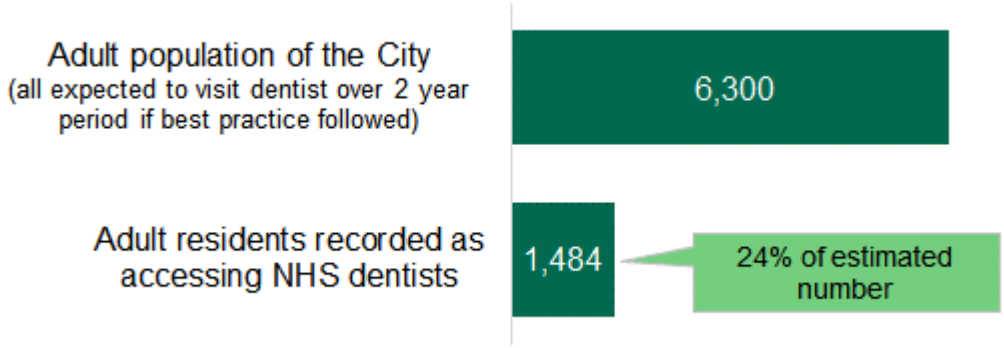
Figure 1: Adult population of Hackney compared to number of Hackney residents recorded as accessing NHS dentists in previous two years (age 18+, March 2017)



Source: Dental access figures by borough of residence provided by Public Health England (PHE) London. Population figures taken for 2016 from Greater London Authority (GLA) strategic housing land availability assessment (SHLAA) projections. [12]

Figure 2 suggests that only 24% of adult residents of the City of London are receiving NHS dental treatment. However, again, this estimate does not take into account those who receive private dental care or travel outside England for their dental care.

Figure 2: Adult population of the City of London compared to number of City residents recorded as accessing NHS dentists in previous two years (age 18+, July 2014–June 2016)



Source: Dental access figures by borough of residence provided by PHE London. Population figures taken for 2016 from GLA SHLAA projections. [12]

In 2009, the *Adult Dental Health Survey* found that in London: [13]

- 26% of those surveyed said they visited a dentist less frequently than every two years, or 'only when having trouble'
- 21% had not visited a dentist in the last two years
- 35% had received their most recent dental care privately or outside the UK
- 5% had no natural teeth
- of those with natural teeth who were examined by a dentist as part of the survey, 28% had active decay.

A local survey in 2008 found that among adult residents of Hackney and the City: [14]

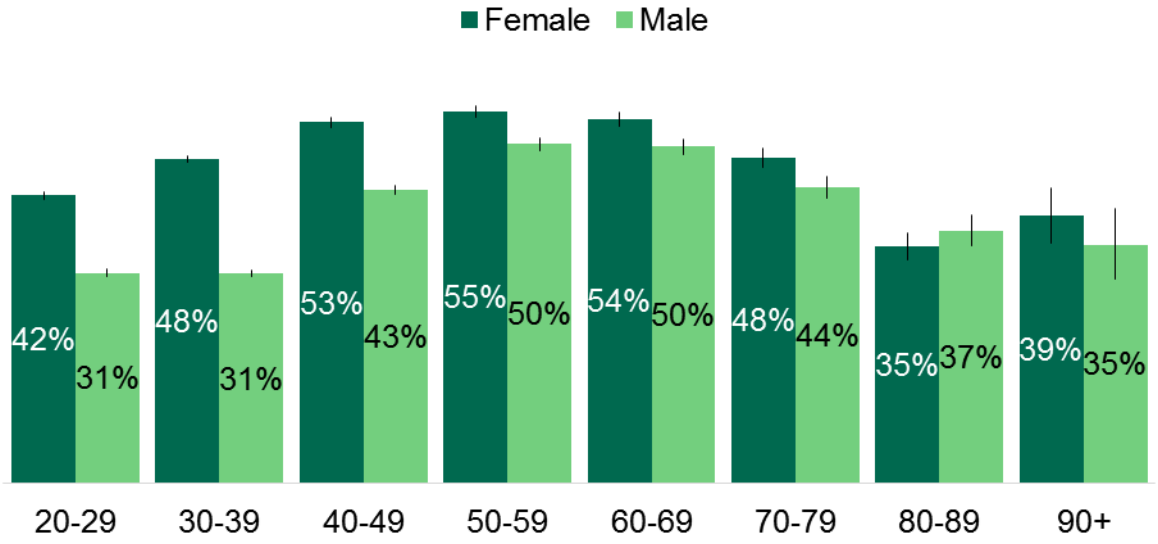
- 7% of those surveyed said they never visit their dentist, and a further 34% 'only when having trouble'
- 72% stated that they brush their teeth at least twice a day
- just under half (47%) had no decayed or unsound teeth, with an average of 1.1 teeth in this condition
- 3% had no natural teeth.

7.4 Inequalities

7.4.1 Age

Figure 3 shows that use of NHS dentists among Hackney residents increases with age for both men and women up to a peak around ages 50-69, after which it declines. Figures for the City of London are not available broken down by age.

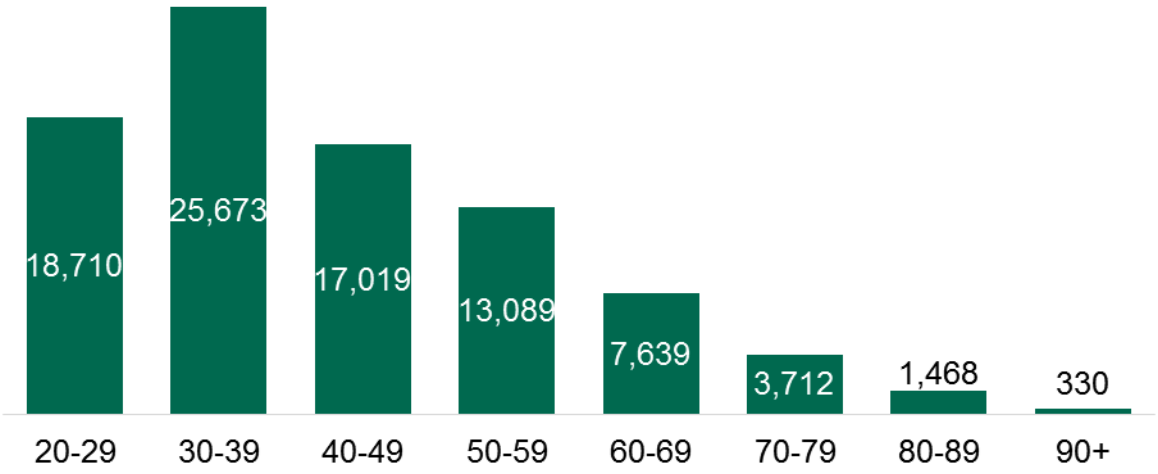
Figure 3: Proportion of Hackney residents who have used an NHS dentist anywhere in England in the preceding two years, by age and gender (March 2017)



Source: Dental access figures by borough of residence provided by PHE London. Population figures taken for 2016 from GLA SHLAA projections. [12]

Despite lower use of NHS dentists among Hackney residents under the age of 40, the young age population profile means that around half of all adult users of dental services are age 20-39 (Figure 4).

Figure 4: Number of Hackney residents who have used an NHS dentist anywhere in England in the preceding two years, by age (March 2017)



Source: Dental access figures by borough of residence provided by PHE London.

Older adults are at increased risk of dental disease due to a number of factors, including the following. [15]

- Long-term conditions, dementia, manual dexterity problems and frailty can affect oral hygiene routines and diet.
- Older adults are more likely to take multiple medications, a side effect of which can be a dry mouth – this can lead to dental disease as food and bacteria are not washed from surfaces.
- Before the introduction of fluoridated toothpastes in the late 1970s, there was a much higher rate of dental caries.
- The effects of dental disease accumulate over time – for example, through the impact of untreated gingivitis and lack of visits to the dental hygienist.

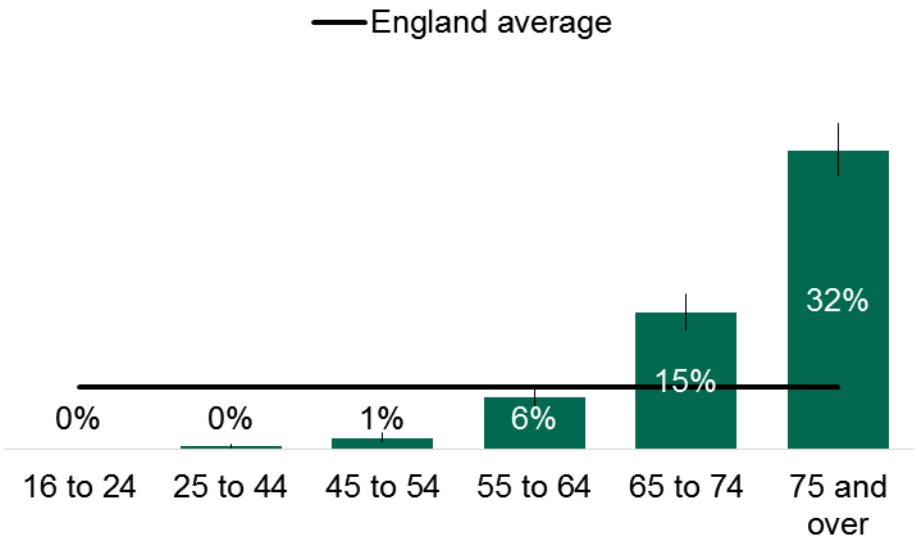
Improvements in oral health over the last 50 years have fundamentally changed the oral health needs of older people at a population level. In the 1960s, most people over the age of 65 had no teeth, while today only 6% of adults aged 65 or over have no teeth. However many older people with natural teeth do have large numbers of fillings, crowns and bridges requiring substantial (and often complex) care.

Figure 5 shows that the risk of having none of your own teeth increases steeply with age – according to the 2009 *Adult Dental Health Survey*, 32% of people age 75 or over in England had no natural teeth, compared to less than 1% of those under 44.

The same survey also found that older adults were slightly more likely than average to have tooth decay (if they did have any natural teeth) and less likely to have seen the dentist in the last two years, while those age 45-64 were slightly more likely to have seen the dentist in the last two years than average. [13]

More detailed findings that confirm these trends locally are shown in a survey of oral health in older adults across Hackney, the City, Newham and Tower Hamlets from 2011. [16]

Figure 5: Proportion of adults in England with no natural teeth, by age (2009)



Source: *Adult Dental Health Survey 2009* [13]

7.4.2 Gender

Overall, 37% of male adult Hackney residents have seen an NHS dentist in the last two years, compared to 48% of female adult residents. However, the difference is greater in younger adults (see Section 7.4.1). Figures for the City of London are not available broken down by gender.

Evidence from the 2009 *Adult Dental Health Survey* suggests that the same disparity is seen nationally, with men less likely to have visited a dentist in the last two years (77% had done so compared to 83% of women) and more likely to have some dental decay if they have any natural teeth (33% compared to 27%). [13]

7.4.3 Ethnicity and religion

The evidence on dental health inequalities by ethnicity is mixed. Nationally, it appears that Black, Asian and Minority Ethnic (BAME) groups have higher rates of dental decay, though this may at least in part be explained by socio-economic differences. There does appear to be some evidence that BAME groups experience more barriers to accessing dental care. [17]

There are no local data on adult dental visits by ethnicity.

Locally, children in the Stamford Hill Orthodox Jewish community are known to have poorer oral health (see Section 3 of the 'Children and young people' chapter of the JSNA). Poor oral health in children leads to poor oral health in adults. There is evidence that the factors contributing to poor oral health in children (i.e. lack of knowledge of good practice, high sugar diets, competing parental priorities, perceived long waiting times for a dentist) are also relevant to adults in this community. [18] [19]

7.4.4 Sexual identity

There is insufficient information on the oral health of people by sexual identity and orientation to draw local inference.

7.4.5 Disability

Disabled people can experience various barriers to oral health, depending on the nature of their disability or disabilities and other factors in their lives.

Barriers experienced by people with disabilities can include: [20] [21] [22]

- lack of cognitive or physical ability to carry out oral hygiene routines
- issues around eating or drinking that may lead to high-sugar diets or food remaining in the mouth for long periods of time
- inability to express oral pain or discomfort clearly
- medications that may lead to dry mouth
- increased likelihood of smoking in those with mental ill health
- carers who are unable to recognise the first signs of oral health problems
- dentists who lack specialist experience in working with this group, or who work in buildings that are not accessible
- increased physical, emotional and financial costs in accessing care due to additional needs.

In the 2009 national survey, people who reported having a limiting long-term condition (LLTC) were more likely not to have any of their own teeth. In under-65s, 4% of those with an LLTC had none of their own teeth, compared to 1% of those without; in over-65s, 26% of those with an LLTC had none of their own teeth, compared to 18% without. However, when age was taken into account, there were no major differences in likelihood of visiting the dentist in the last two years or likelihood of dental decay between those with and without an LLTC. [13]

A similar national survey of adults with learning disabilities found that in comparison to the general population (from the 2009 *Adult Dental Health Survey*), this group had fewer teeth present, had higher rates of decay, and were less likely to brush daily. [23] Local data from the neighbouring borough of Tower Hamlets found similar trends. [24]

Care home patients, who tend to be older and/or have complex health and care needs, are also at increased risk of poor oral health. [25]

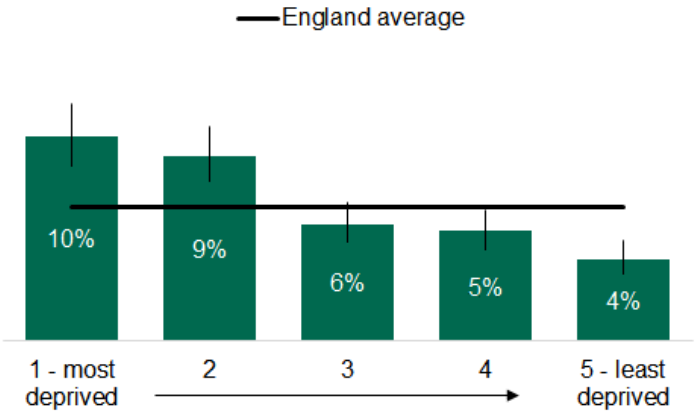
7.4.6 Socio-economic disadvantage

Deprivation is strongly linked to poorer oral health. Data from the 2009 national survey illustrates the links between deprivation and poorer oral health outcomes.

- Figure 6 shows that nationally those in the most deprived quintile are over twice as likely as those in the least deprived quintile to have no natural teeth (10% compared to 4%).

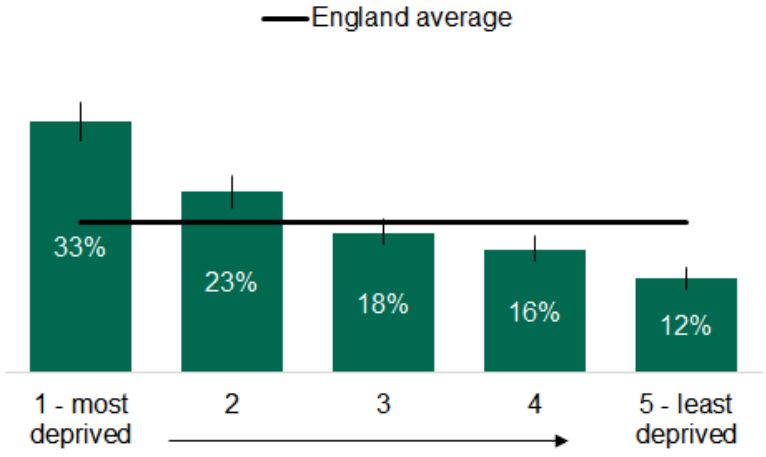
- Figure 7 shows that those in the most deprived quintile are over two and a half times as likely not to have visited a dentist in the last two years (33% compared to 12% of those in the least deprived quintile).
- Figure 8 shows that those in the most deprived quintile are nearly twice as likely to have tooth decay if they have any natural teeth (42% compared to 24%).

Figure 6: Proportion of adults in England with no natural teeth, by deprivation quintile (age 16+, 2009)



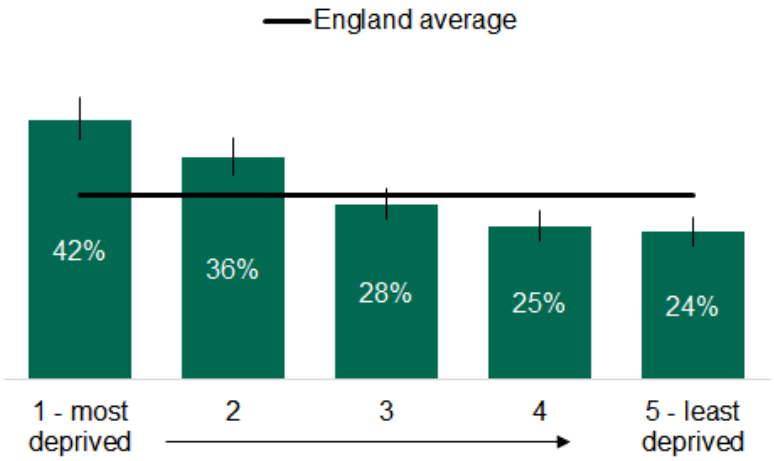
Source: *Adult Dental Health Survey 2009* [13]
Note: Data available by 2015 national deprivation quintiles. 91% of Hackney residents live in the two most deprived national quintiles. Deprivation is defined using the Index of Multiple Deprivation 2015 (IMD). IMD is a measure of relative deprivation for small areas that combines 37 separate indicators, each reflecting a different aspect of deprivation experienced by individuals living in an area. Deprivation groupings are reported from 1 (most deprived) to 5 (least deprived).

Figure 7: Proportion of adults in England who have not visited a dentist in the last two years, by deprivation quintile (age 16+, 2009)



Source: *Adult Dental Health Survey 2009* [13]
Note: Data available by 2015 national deprivation quintiles. 91% of Hackney residents live in the two most deprived national quintiles. Deprivation is defined using the Index of Multiple Deprivation 2015 (IMD). IMD is a measure of relative deprivation for small areas that combines 37 separate indicators, each reflecting a different aspect of deprivation experienced by individuals living in an area. Deprivation groupings are reported from 1 (most deprived) to 5 (least deprived).

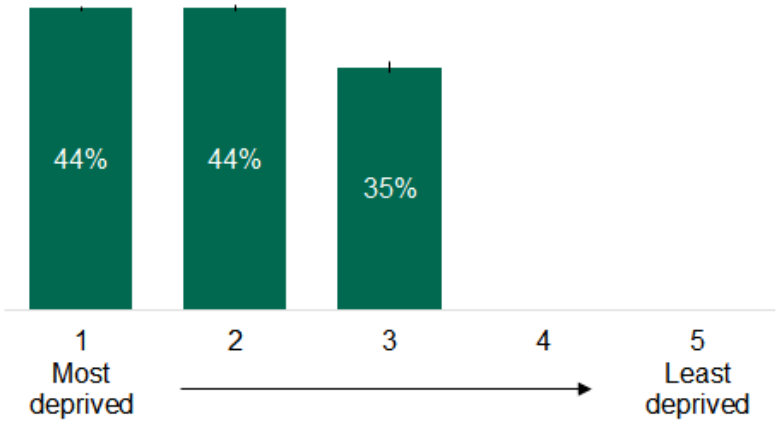
Figure 8: Proportion of adults in England with at least one natural tooth who have some tooth decay, by deprivation quintile (age 16+, 2009)



Source: *Adult Dental Health Survey 2009* [13]
Note: Data available by 2015 national deprivation quintiles. 91% of Hackney residents live in the two most deprived national quintiles. Deprivation is defined using the Index of Multiple Deprivation 2015 (IMD). IMD is a measure of relative deprivation for small areas that combines 37 separate indicators, each reflecting a different aspect of deprivation experienced by individuals living in an area. Deprivation groupings are reported from 1 (most deprived) to 5 (least deprived).

Within Hackney, those living in areas of relatively high deprivation are actually more likely to have visited an NHS dentist in the last two years than those living in more affluent neighbourhoods (Figure 9). Figures are not available for the City of London broken down by deprivation quintile.

Figure 9: Proportion of adult Hackney residents who have used an NHS dentist anywhere in England in the preceding two years, by national deprivation quintile (age 18+, March 2017)

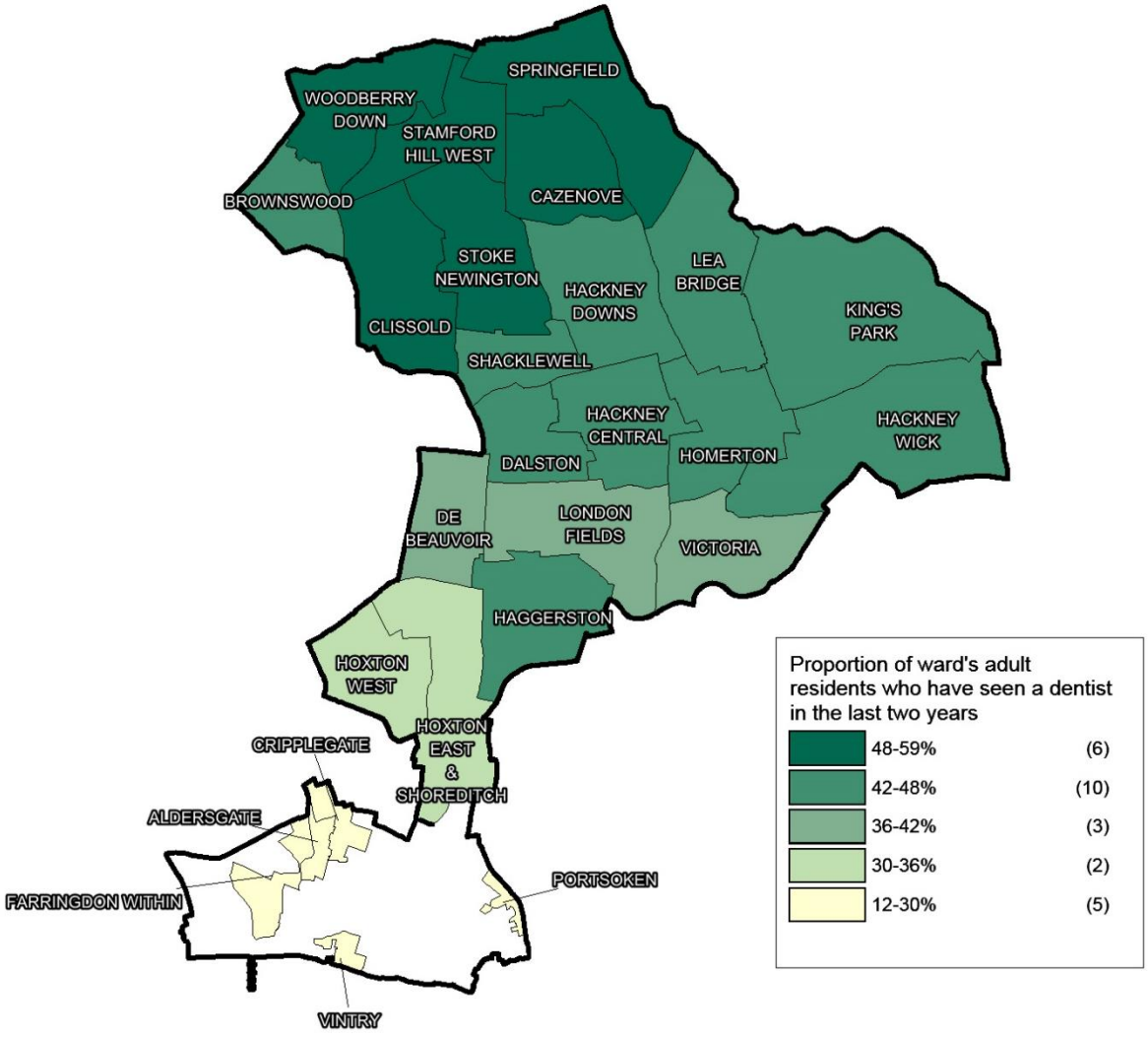


Source: Dental access figures by borough of residence provided by PHE London.
Note: Data available by 2015 national deprivation quintiles. 91% of Hackney residents live in the two most deprived national quintiles. Deprivation is defined using the Index of Multiple Deprivation 2015 (IMD). IMD is a measure of relative deprivation for small areas that combines 37 separate indicators, each reflecting a different aspect of deprivation experienced by individuals living in an area. Deprivation groupings are reported from 1 (most deprived) to 5 (least deprived).

7.4.7 Location with Hackney and the City

Figure 10 shows use of NHS dental services among adults by ward of residence. In Hackney, use of services is higher in the north of the borough and lower in the south. In the City, service use is comparatively low throughout (although slightly higher in Portsoken in the east).

Figure 10: Proportion of adult Hackney and the City residents who have used an NHS dentist anywhere in England in the preceding two years, by ward of residence (age 18+, March 2016)



Source: Dental access figures by borough of residence provided by PHE London.

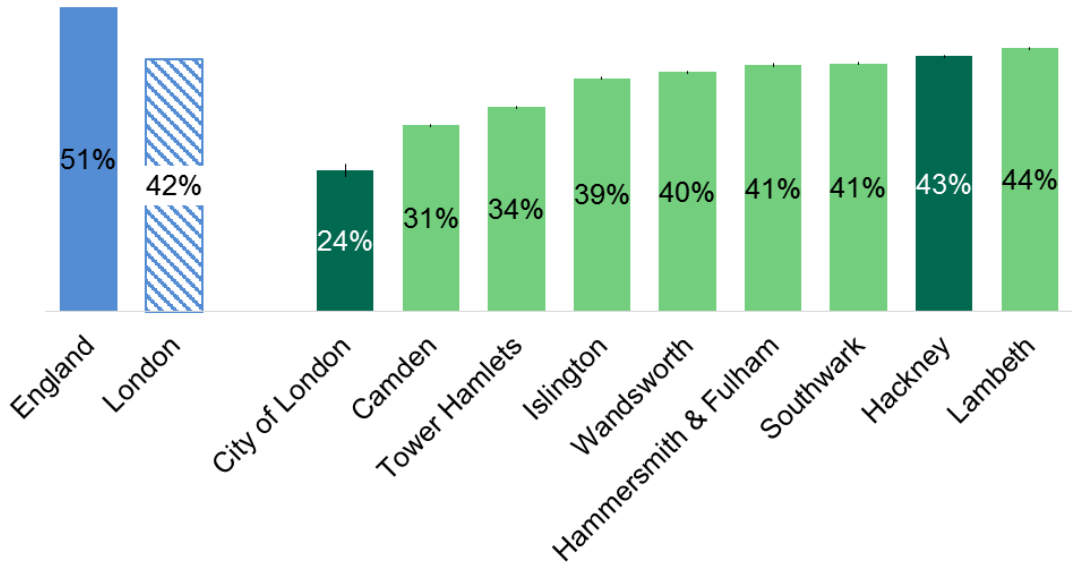
7.5 Comparisons with other areas and over time

7.5.1 Use of NHS dental services

Figure 11 shows that the proportion of adults accessing NHS dentists in Hackney is similar to London and comparable boroughs, but lower than England. The City of London has much lower rates than England, London and Hackney's statistical peer group.

Data are not available for resident use of NHS dentists over time. However, we do have trend data on use of NHS dental services by location of the service. This is not the same as resident use,[1] but may give some indication of trends. Figure 12 shows that use of Hackney-based NHS dental practices has decreased slightly between 2013 and 2017, while use of City of London-based practices has increased dramatically.

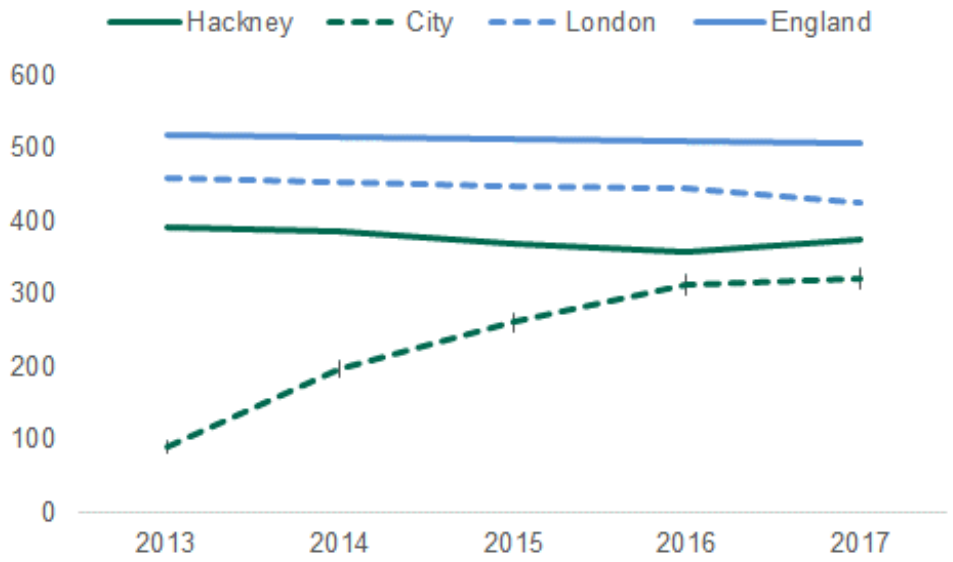
Figure 11: Proportion of adult residents seen by NHS dentists anywhere in England in the previous two years (March 2017)



Source: Dental access figures by borough of residence provided by PHE London. Population figures taken for 2016 from GLA SHLAA projections. [12]

[1] In the two years preceding March 2017, the number of people from anywhere in England using Hackney-based services was 19% lower than the number of Hackney residents using services anywhere in England. Over the same time period, the number of people from anywhere in England using City-based services was 24% higher than the number of City residents using services anywhere in England.

Figure 12: Adult patients from anywhere in England seen by NHS dentists in the named area in the previous two years per 1,000 adult residents over time (June 2013 — June 2017)

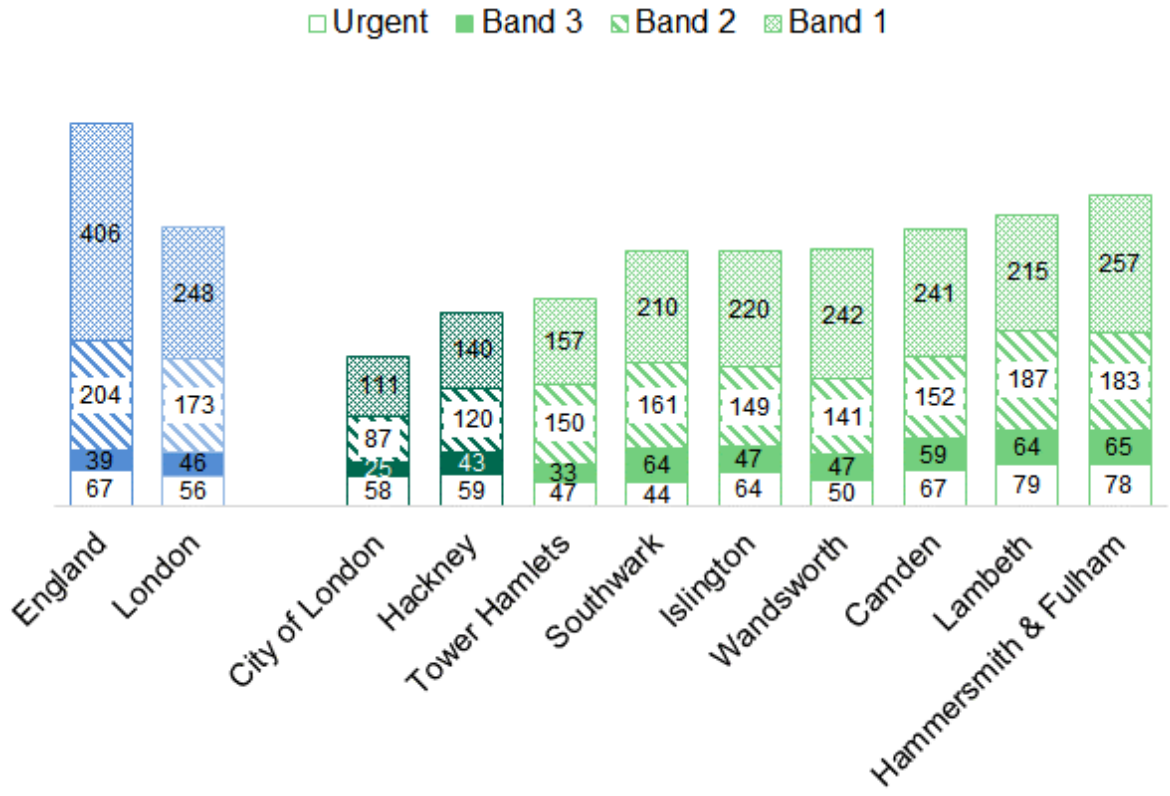


Source: NHS dental care figures from NHS Dental Statistics for England 2016/17, NHS Digital. [26] Population estimates taken from GLA population estimates. [12]

Figure 13 presents data on use of NHS dental services by treatment band. Data on type of treatment are not available split by age group, so rates of treatment for the whole population (adults and children) are presented here. As with Figure 12, these data are for patients from anywhere in England seen by NHS dentists in the named locations, and so are merely indicative of the needs of residents in these areas.

Figure 13 shows that there are relatively low rates of Band 1 (preventative) treatment within Hackney and the City. The City of London's Band 1 treatment rate is less than half the London average, and Hackney's is just over half. These differences from the London average decrease as the complexity of treatment increases for Band 3 (Hackney) and Urgent treatment (Hackney and the City), treatment rates are very close to the London average.

Figure 13: Number of courses of NHS treatment performed by treatment band per 1,000 residents (all ages, 2015/16)

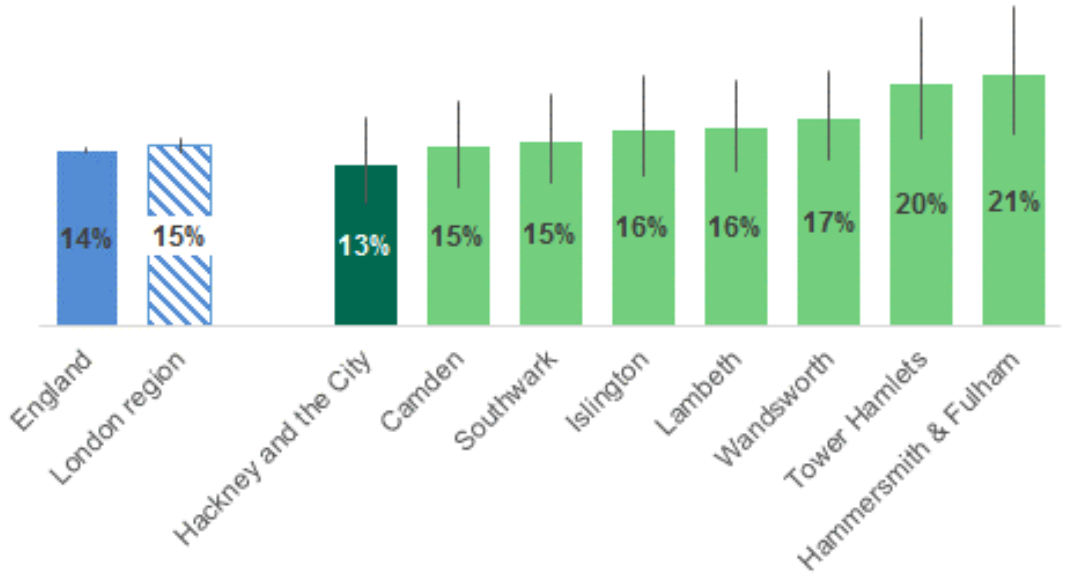


Source: NHS dental care figures from NHS Dental Statistics for England 2015/16, NHS Digital. [26]
Population estimates taken from GLA population estimates. [12]
Note: For more information on treatment bands, see Table 1.
Note: Confidence intervals not available.

7.5.2 Oral cancer registrations

Age standardised rates of oral cancer registration in Hackney and the City of London are similar (i.e. not statistically different) to the rates in England, London and comparator boroughs, as shown in Figure 14.

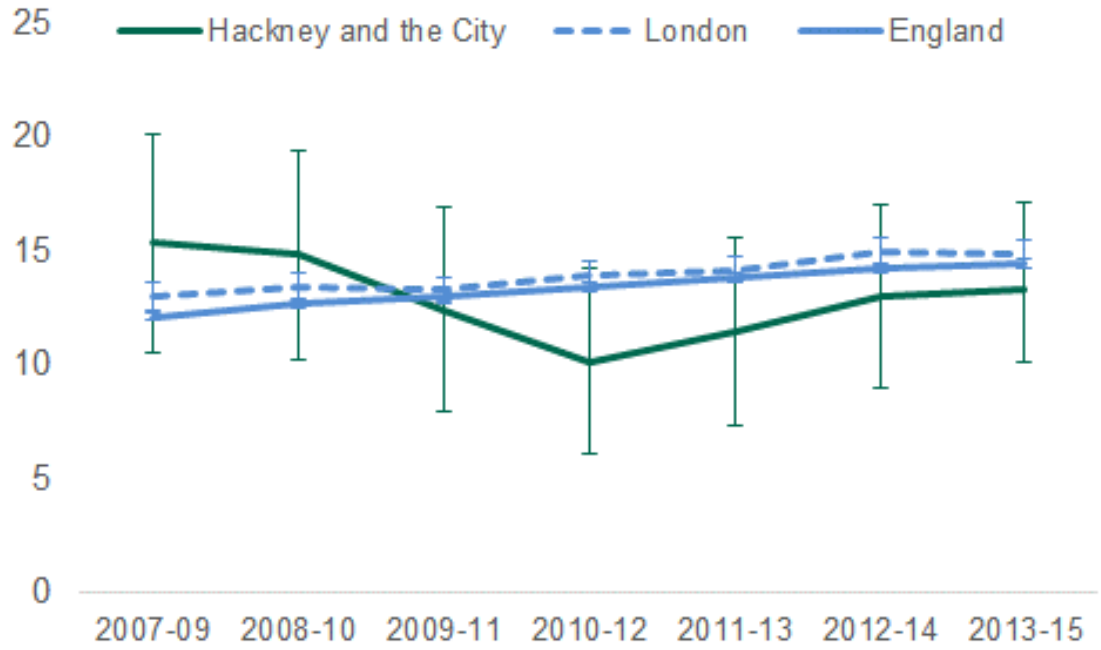
Figure 14: Age standardised rate of oral cancer registrations per 100,000 residents (2013–15)



Source: PHE National Cancer Registration and Analysis Service. All cancer registrations for lip, oral cavity and pharynx (ICD-10, C00-C14) in the calendar years 2007–09 to 2013–15. This does not include secondary cancers.

Nationally, rates of oral cancer have risen rapidly since 1989, and a continued upward trend is evident in recent data for London and England, as shown in Figure 15. [27] Given the small number of cases involved (i.e. large confidence intervals), there is no evidence of a statistically significant change in the local rate in recent years.

Figure 15: Age standardised rate of oral cancer registrations per 100,000 residents over time (2007–09 to 2013–15)



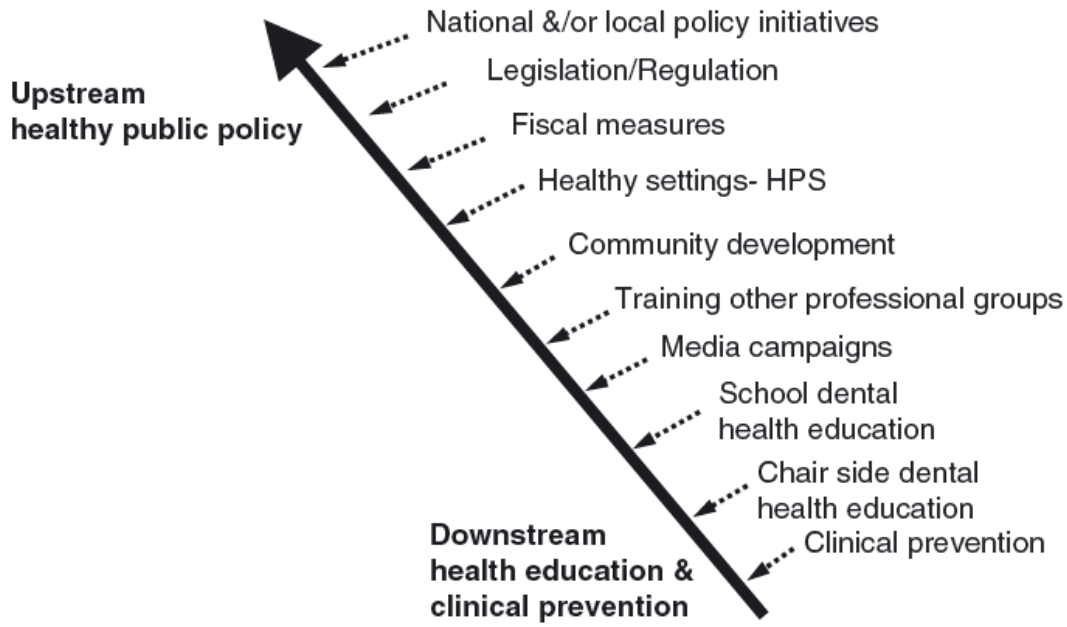
Source: PHE National Cancer Registration and Analysis Service. All cancer registrations for lip, oral cavity and pharynx (ICD-10, C00-C14) in the calendar years 2007–09 to 2013–15. This does not include secondary cancers.

7.6 Evidence and good practice

7.6.1 Prevention

In preventing poor oral health, dental decay must be considered as a disease with many contributing factors; there is no single solution. Good oral health must be considered to be everyone's business, and integrated into other commissioned programmes – with interventions upstream, midstream and downstream (see Figure 16). [28]

Figure 16: The range of interventions to prevent poor oral health



Source: Watt (2007) [28]

Individuals

As discussed in Section 7.3.2, adults should visit a dentist at least once every two years, depending on their risk of dental disease. [11] Teeth should be brushed twice a day with fluoridated toothpaste for about two minutes each time, and a healthy diet should be followed. [29] Preventable risk factors such as smoking, alcohol and high sugar intake, for example from sugar-sweetened drinks, should be reduced or avoided.

For adults with additional care needs, it is important to ensure they have daily support to carry out routine oral hygiene – this includes brushing teeth twice a day (as for all adults), dental flossing, regular visits to the dental hygienist, and reducing or avoiding risk factors. In care homes, residents should know which members of staff they can ask for advice, and staff should understand the importance of oral care and the impact of oral pain on wellbeing. [25]

Healthcare professionals

NICE guidance states that dentists should: [30]

- give patients individually tailored advice during dental examinations about oral hygiene, diet, smoking and smokeless tobacco, and alcohol
- listen carefully to patients, and understand the wider determinants of health that may affect the patient's oral care.

For adults who move into care homes, it is recommended that they have their oral care needs assessed on admission. For adults currently living in care homes it is recommended they have their oral care needs recorded in their personal care plan,

and that they are supported to clean their teeth twice a day and carry out daily care for their dentures. [25] Care home residents should know which members of staff they can ask for advice, and staff should be trained to understand the importance of oral health and the contribution to general health, wellbeing and dignity.

Local authorities and other public bodies

There is strong evidence that increasing the availability of fluorides[2] in an area reduces the prevalence of caries. This can be done through adding fluorides to the water supply or to milk, encouraging people to use toothpastes with high levels of fluoride, or provision of fluoride tablets and/or application of treatments such as fluoride varnish, particularly in children. [8] Across England, almost 6m people receive drinking water with added fluoride – notably in Birmingham. [31] There are some particular technical and political challenges associated with fluoridation in London. [32]

7.6.2 Identification and early intervention

The best opportunity for identification of oral health issues is through regular dental checks by a dentist. [11]

For adults with additional care needs, it is important that carers are aware of potential signs of mouth pain, especially in those who cannot clearly articulate their pain or ask for help. Adults in care homes must be provided with routine access to dental checks – where it is not possible for residents to visit and use dental practices due to care or accessibility needs, arrangements should be in place to ensure that dentists provide routine checks on site. [25]

7.6.3 Treatment, care and support

Where oral health treatment is required, dentists should ensure that patients are fully informed about potential treatments, costs and outcomes, and whether part or all of each potential treatment is available on the NHS. [33]

For adults in care homes, arrangements must be in place to ensure that residents can access dental treatment, including treatment that cannot be provided on site. [25]

7.7 Services and support available locally

7.7.1 Prevention

The oral health promotion service in Hackney and the City of London is provided by Kent Community Health NHS Foundation Trust. Oral health promotion activities are

[2] 'Fluorides' are chemical compounds containing the element fluorine. They are found naturally in certain foods and some water supplies.

targeted at community groups, care homes and at community events. In addition, all general dental practitioners in the area are expected to provide practice-based oral health promotion in line with guidance in Public Health England's 'Delivering better oral health: an evidence-based toolkit for prevention'. [8]

Key programmes being delivered are:

- oral health training for the wider professional workforce
- integration of oral health into targeted visits by social workers
- implementation of oral health standards in care homes
- use of fluoride products for prevention of tooth decay in older people
- local implementation of national initiatives such as National Smile Month and Mouth Cancer Action Month awareness programmes.

7.7.2 Identification and early intervention

All clinical dental services for adults are commissioned by NHS England. This includes general, community and specialist care, and hospital and out-of-hours urgent dental care services. NHS England is therefore responsible for the commissioning and performance management of clinical dental services in Hackney and the City.

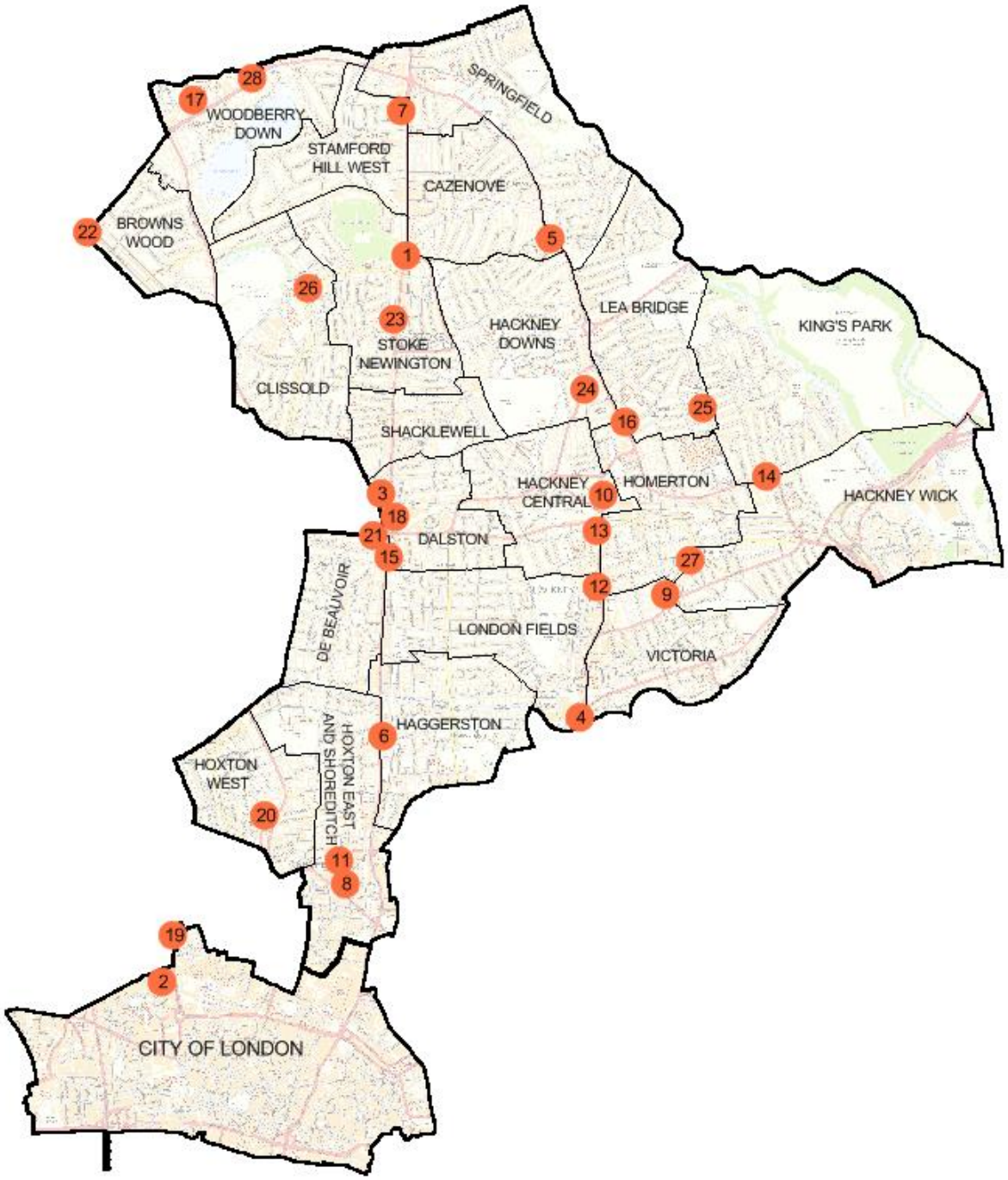
Primary care dental services in Hackney and the City are mainly provided by independent contractors within the general dental service. A community dental service hosted by Kent Community Health NHS Foundation Trust is responsible for providing dental care for adults with special needs, oral health promotion and undertaking dental epidemiological surveys.

Clinical dental services in Hackney and the City consist of:

- 28 NHS dental practices – 26 in Hackney and two in the City (see Figure 17 and Table 2)
- a community dental service
- an out-of-hours urgent care service provided via NHS 111
- hospital dental services providing specialist care, mainly at the Royal London and Homerton hospitals.

Table 3 shows recent data from the Care Quality Commission (CQC) that identify a total of 34 regulated dental premises in the City, and 37 in Hackney. [34] Given the relatively low levels of socio-economic deprivation in much of the City of London, along with the high numbers of commuters, there is a higher demand for private services.

Figure 177: Map of NHS dental practices in Hackney and the City (2017)



Source: List provided by PHE London.

Table 2: Map key for Figure 177

Map number	Practice name	Practice post code
1	Abney Dental	N16 7HU
2	Barbican Orthodontics	EC1A 9ET
3	Bradbury Dental Surgery	N16 8JN
4	City Smile Dental Practice	E8 4RP
5	Clapton Dental Surgery	E5 9BU
6	Cosmo Clinic Ltd	E2 8EB
7	Davidoff Dental Practice	N16 5TR
8	Dentessentials Dental Care	EC2A 3BS
9	Donnelly Dental Practice	E9 7LJ
10	E8 Dental Care	E8 1HR
11	EC1 Dental Practice	EC1V 9DS
12	F Mian Dental Surgery	E8 3NS
13	Hackney Dental Practice	E8 1EJ
14	Homerton Dental Care	E9 6BB
15	Kingsland Dental Surgery	E8 4AR
16	Lower Clapton Dental Surgery	E5 0RN
17	Manor Orthodontics	N4 1SN
18	Mudhar & Reel Dental Surgery	E8 2JS
19	Newham Family Dental Care	EC1M 7AA
20	Nile Street Dental Practice	N1 7RD
21	Orchid Dental Care	N1 4AX
22	Smile and Shine Dental Practice	N4 2AA
23	Stoke Newington Dental Practice	N16 8EL
24	Trinity Dental Care	E5 8EE
25	Upper Clapton Dental Surgery	E5 0LH
26	Vital Dental Care	N16 0UL
27	Well Street Dental Practice	E9 6QT
28	Woodberry Downs Dental Practice	N4 1QR

Source: Provided by PHE London.

Table 3: Total number of local dental premises and NHS dental practices (Public Health England London, CQC 2017)

	Total premises (CQC)	Total NHS dentists (PHE)
Hackney	37	26
City of London	34	2

7.7.3 Treatment, care and support

The Community Dental Service (CDS) in Hackney and the City is hosted by Kent Community Health NHS Foundation Trust and provides dental services for people with special care needs, including:

- adults with severe physical or learning disabilities
- adults with severe mental illness

- adults with complicated medical histories
- adults with severe dental phobia
- adults who require sedation services
- a domiciliary dental service for housebound people.

Dental services are provided for psychiatric inpatients at Homerton Hospital and the John Howard Centre medium secure unit in Hackney. Patients are seen on the wards or are referred to St Leonard's Hospital CDS clinic. People with mental health issues living in supported accommodation in the community are offered services at the CDS clinics or, if appropriate, referred to general dental services. The service works closely with various teams in the hospital, social workers and organisations such as mental health charity Mind.

The CDS is the sole provider of domiciliary dental services for adults in Hackney and the City. The service exists for housebound patients from Monday to Friday. Housebound patients include frail elderly people, people with dementia and those with severe physical and learning disabilities. Referrals are accepted from health and social care providers for patients meeting the eligibility criteria. Care is provided in the patient's own home, as well as nursing and residential homes, day centres and in hospital.

Conscious sedation is an important and effective method of managing adult dental patients who have a severe dental phobia, medical or behavioural indicators or people needing complex treatments. The CDS is the sole provider of sedation services in Hackney and the City.

The CDS also provides fieldwork for the national dental epidemiology programme, which comprises of annual surveys designed to assess population need, and monitoring of interventions. The survey for 2016/17 focused on five-year-old children and the one for 2017/18 will focus on adults.

The out-of-hours urgent care dental service provides care for patients in the evening, at weekends and on bank holidays. To access this service, Hackney and the City residents need to telephone NHS 111, where they are triaged by a dental nurse and if necessary directed to treatment services. Treatments are provided on several sites across London. Hackney and the City residents are able to access urgent care dental services at any of these sites.

Hospital dental services provide specialist care for local residents. The main providers for Hackney residents are the Royal London and Homerton hospitals. The main specialist services are oral surgery, orthodontics, paediatric and restorative dentistry.

7.8 Service gaps and opportunities

Hackney and the City have growing and ageing populations, which are likely to increase demand on dental services in coming years. Public Health England will be releasing a guide on commissioning better oral health for vulnerable older people to support the commissioning of prevention and care for this growing population.

In addition, Smile4Life is a Chief Dental Officer project, covering initiatives both national and local, which gives a branding to schemes aimed at improving oral health. Phase 2, which is expected to start in 2018, will look at older people – it aims to increase the knowledge and application of the NHS Health Education England Mouth Care Matters programme in NHS trusts and care homes. [35]

There is also a new national dental contract on the horizon, which aims to shift services to prevention, providing a new model that recognises the shared responsibility for health between the care provider and the patient.

7.9 References

[1] WHO, “The World Oral Health Report,” 2003. [Online]. Available: http://www.who.int/oral_health/media/en/orh_report03_en.pdf.

[2] Institute for Health Metrics and Evaluation, “GBD Compare Data Visualization.,” Seattle, WA: IHME, University of Washington, 2017. [Online]. Available: http://vizhub.healthdata.org/gbd-compare. [Accessed 15 November 2017].

[3] NHS Choices, “HPV Vaccine,” 2017. [Online]. Available: https://www.nhs.uk/conditions/vaccinations/hpv-human-papillomavirus-vaccine/. [Accessed 16 March 2018].

[4] D. Kandelman, P. Peterson and H. Ueda, “Oral health, general health, and quality of life in older people,” *Special Care in Dentistry,* vol. 28, no. 6, pp. 224-236, 2008.

[5] NHS Choices, “Tooth decay,” [Online]. Available: http://www.nhs.uk/conditions/dental-decay/Pages/Introduction.aspx. [Accessed 21 April 2017].

[6] NHS Choices, “How much will I pay for NHS dental treatment?,” [Online]. Available: http://www.nhs.uk/chq/Pages/1781.aspx?CategoryID=74. [Accessed 13 April 2017].

[7] NHS Choices, “Who is entitled to free NHS dental treatment in England?,” 2017. [Online]. Available: https://www.nhs.uk/chq/Pages/1786.aspx?CategoryID=74&SubCategoryID=742. [Accessed 16 March 2018].

[8] Public Health England, “Delivering better oral health: an evidence-based toolkit for prevention,” 22 March 2017. [Online]. Available: https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention. [Accessed 10 May 2017].

[9] NHS Choices, “Gum disease,” 2016. [Online]. Available: https://www.nhs.uk/conditions/gum-disease/causes/.

[10] Dental access figures by borough of residence provided by PHE London.

[11] National Institute for Health and Care Excellence, “Dental checks: intervals between oral health reviews [CG19],” 2004.

[12] Greater London Authority, “Housing-linked projection incorporating data from the 2013 SHLAA: Interim 2015-based population projections,” February 2017. [Online]. Available: https://data.london.gov.uk/dataset/gla-population-projections-custom-age-tables. [Accessed 13 April 2017].

[13] Office for National Statistics. Social Survey Division, Information Centre for Health and Social Care, “Adult Dental Health Survey, 2009,” UK Data Service, 2012.

[14] Awojobi, Wright, Pearson, Islam and Croucher, “Oral Health of Adults in Inner North East London,” Tower Hamlets, Newham, City & Hackney PCTs, 2009.

[15] Public Health England, “What is known about the oral health of older people in England and Wales: a review of oral health surveys of older people,” 6 January 2016. [Online]. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/489756/What_is_known_about_the_oral_health_of_older_people.pdf. [Accessed 21 April 2017].

[16] W. Marcenes, V. Muirhead, D. Wright, P. Evans, E. O'Neill and F. Fortune, “The oral health of older adults in East London and the City,” NHS East London and the City / Barts and the London School of Medicine and Dentistry, 2011.

[17] Z. Marshman, K. Nower and D. Wright, “Oral health and access to dental services for people from black and minority ethnic groups,” Race Equality Foundation, 2013.

[18] S. Scambler, C. Klass, D. Wright and J. E. Gallagher, “Insights into the oral health beliefs and practices of mothers from a north London Orthodox Jewish community,” *BMC Oral Health,* vol. 14, no. 10, 2010.

[19] C. Klass, A. Mondkar and D. Wright, “Oral health and oral health behaviours of five-year-old children in the Charedi Orthodox Jewish Community in North London, UK,” *Community Dental Health,* no. 34, pp. 60-64, 2017.

[20] British Society for Disability and Oral Health; Faculty of Dental Surgery, The Royal College of Surgeons of England, “Clinical Guidelines and Integrated Care Pathways for the oral Health Care of People with Learning Disbilities,” 2012. [Online]. Available: http://www.bsdh.org/documents/pBSDH_Clinical_Guidelines_PwaLD_2012.pdf. [Accessed 21 April 2017].

[21] British Society for Disability and Oral Health, “Oral Health Care for People with Mental Health Problems: Guidelines and Recommendations,” January 2000. [Online]. Available: http://www.bsdh.org/documents/mental.pdf. [Accessed 21 April 2017].

[22] British Society for Disability and Oral Health, “Guidelines for Oral Health Care for People with a Physical Disability,” January 2000. [Online]. Available: http://www.bsdh.org/documents/physical.pdf. [Accessed 21 April 2017].

[23] Public Health England, “Dental health among adults with learning disabilities in England,” 2017. [Online]. Available: http://www.nwph.net/dentalhealth/adult/Adultswithlearningdisabilitiesdentalsummary.pdf.

[24] Wright, Patel and Ward, “Oral health of adults with learning disabilities in Tower Hamlets, UK,” NHS Tower Hamlets (Unpublished), 2011.

[25] National Institute for Health and Care Excellence, “Oral health for adults in care homes [NG48],” July 2016. [Online]. Available: https://www.nice.org.uk/guidance/ng48/chapter/Recommendations. [Accessed 10 May 2017].

[26] NHS Digital, “NHS Dental Statistics for England - 2015-16,” 23 September 2016. [Online]. Available: http://www.content.digital.nhs.uk/catalogue/PUB21701. [Accessed 13 April 2017].

[27] Cancer Research UK, “Oral cancer incidence statistics,” 2017. [Online]. Available: http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/oral-cancer/incidence.

[28] R. Watt, “From victim blaming to upstream action: tackling the social determinants of oral health inequalities,” *Community Dentisty & Oral Epidemiology,* vol. 35, no. 1, pp. 1-11, 2007.

[29] NHS Choices, “How to keep your teeth clean,” 25 November 2015. [Online]. Available: http://www.nhs.uk/Livewell/dentalhealth/Pages/Teethcleaningguide.aspx. [Accessed 21 April 2017].

[30] National Institute for Health and Care Excellence, “Oral health promotion: general dental practice [NG30],” December 2015. [Online]. Available: https://www.nice.org.uk/guidance/ng30. [Accessed 21 April 2017].

[31] Public Health England, “Improving oral health: a community water fluoridation toolkit for local authorities,” March 2016. [Online]. Available: https://www.gov.uk/government/publications/improving-oral-health-community-water-fluoridation-toolkit. [Accessed 15 March 2018].

[32] London Assembly, “Should Fluoride be added to London's Water?,” 2003. [Online]. Available: https://www.london.gov.uk/sites/default/files/gla_migrate_files_destination/archives/assembly-reports-health-fluoridation.pdf. [Accessed 15 March 2018].

[33] General Dental Council, “Standards for the Dental Team,” September 2013. [Online]. Available: https://www.gdc-uk.org/professionals/standards. [Accessed 17 May 2017].

[34] CQC, “Locations regulated by the CQC,” 2017. [Online]. Available: http://www.cqc.org.uk/about-us/transparency/using-cqc-data.

[35] NHS Health Education England, “Mouth Care Matters,” [Online]. Available: http://www.mouthcarematters.hee.nhs.uk/. [Accessed April 2018].

[36] NHS Choices, “Mouth cancer - Overview,” [Online]. Available: http://www.nhs.uk/conditions/cancer-of-the-mouth/pages/introduction.aspx. [Accessed 2017 April 20].

[37] Public Health England, “Delivering better oral health: an evidence-based toolkit for prevention,” 12 June 2014. [Online]. Available: https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention. [Accessed 21 April 2017].