MAY 2005

ORAL HEALTH STRATEGY FOR JERSEY 2005-2010

1. STRATEGIC AIM

To improve the oral health of the residents of Jersey.

2. REMIT

This Strategy is commissioned and developed from within the H&SS to look at not only its directable resources, but also to examine its wider interactions with other agencies and establishments, (Other Committee departments, the Private health sector, other health and educational professionals, charitable and voluntary organisations, the public).

With regard to service provision, the main thrust of the Strategy is concerned with Primary Care delivery, but will inevitably touch on secondary and tertiary elements to a lesser degree where appropriate.

The Strategy will provide a framework for the next five years, adaptable to change in response to new influences, strategic performance and resource availability.

3. BACKGROUND

Oral health in developed countries demonstrates a common scenario, shared by Jersey

Health issues (evidenced by local studies) -

- Inequalities in disease experience as shown by epidemiology
- Inequalities in access, take-up of treatment services
- effect of social-economic factors in producing health disparities
- evidence that this health "gap" may be increasing

Funding issues –

- cost of providing healthcare has risen
- new technology costly – equipment, materials, training
- demands upon central government spending in general – looking for best value, savings, efficiency and cost effectiveness
- resource limitations vs normative / expressed need dilemma
- in view of above, need to prioritise

Changing philosophies in healthcare –

- shift in emphasis from "illness culture" to "health maintenance" i.e. prevention not cure.
- Increased investment in health promotion and preventive strategies; concepts of high-risk and population approaches in preventive initiatives
- Directable state-funded services moving away from demand-led to needs-based targeting
- recognition of personal responsibility for self-care

- awareness that differing background and lifestyle factors amongst the population means that prescriptive treatment and preventive ideologies may not be universally appropriate
- partnerships and holistic approach; dentistry, historically isolated from general healthcare, must adapt
- recognition of the importance of client-centred seamless pathways of care

Social changes

- demographic change – aging population, immigration
- social structure changes e.g. increase in one-parent families, elderly dependency
- increased public expectations of healthcare and treatment possibilities
- increased public desires re. Self-image and consequent demands; may be unrealistic, maybe at odds with traditional prescriptive dentistry / state-funded service objectives
- increased litigation culture

Lifestyle changes

- unhealthy dietary choices, effects not only on oral health but also consequent obesity and general health sequelae
- sophisticated marketing initiating and maintaining unhealthy behaviour e.g. carbonated drinks
- increased smoking especially amongst youngsters
- drugs culture

Legislative, professional and quality issues

- Reference to major professional reform in UK dentistry
- Professions Complementary to Dentistry (PCD) - expanded duties of auxiliary staff ratified by changes in UK Dentist Act
- Health & Safety, consent, infection control
- increased incidence of serious infective risks from blood-borne pathogens e.g. HIV, AIDS, CJD
- Continuous Professional Development (CPD), re-registration
- Clinical Governance and audit requirements
- Best Practice and evidence based practices – National Institute for Clinical Excellence (NICE)
- Complaints pathways, reform to protect patients

3. DEVELOPMENT OF THE STRATEGY

The nature of the Strategy is so wide ranging that many distinct health themes are involved. The practical reality of this project is visualized as a framework into which several "modules" may be fitted; these are identified in the following sections. Some action plans will be more along the road of development than others, some will involve completely new structures. Although necessarily integral parts of the whole process, in a practical sense they will become separate issues for planning purposes, consultation and execution.

4. PROCESS, CONSULTATION, EVOLUTION

Development of Strategy document by Oral Health Strategy Group (describe membership). Initial delivery to H&SS Committee.

Wider consultation – States - other States Committees (including those with direct impact upon Health e.g. Social Security, and those not e.g. Education), Social Policy Strategy Group.

- other health care professionals – States-funded e.g. residential/nursing homes; private sector - GDP's, GP's, charitable and voluntary e.g. Nursing & Home Care.
- Public and Community

Action Plans – consultation will be an integral part of the strategic evolutionary process. In addition to the bodies outlined above, other interested agencies will be identified as planning and implementation progresses.

Feedback – the more advanced modules will be refined.

New programmes developed, and fed into the strategic framework

The whole will evolve in response to disease, environmental, social, funding changes. Regular revisiting mechanisms will be emplaced to allow and control this organic system.

Monitoring of the progress towards strategic objectives will be benchmarked by inbuilt targets (qualitative and quantitative as appropriate) and timelines. New indicators may need to be developed during the process.

5. STRATEGIC & LEGISLATIVE CONTEXT

The Strategy must reflect the ethos expressed in recent social and health related publications both locally and globally

States of Jersey Strategic Plan 2005-2010

- One of the Plan's "Aspirations" – Jersey is a 'community where people benefit from equality in access and opportunity'
- Strategic Aim 'to enhance the quality of life by greater equity in ...health provision'
- "achieving health for all" – success indicators -
    - greater integration of services
    - levels of care which compare favourably with accepted professional standards
    - increased public/private sector partnerships
    - resource sharing with other communities
    - community support strengthened
    - improved access to health information and services

Jersey – "Improving health and Social Care 2001-2005" H&SS
The Oral Health Strategy must necessarily be embraced by the philosophy of care as described in this document -
Overall aims of H&SS

- "promoting the health and social well-being….."
- "providing prompt, high quality services ….."
- "protecting the interests of the frail ….."

Its seven themes – collaboration, development, equity and access, integrated and client centred care, quality and clinical effectiveness, efficiency and long-term sustainability, infrastructure provision.

Professional, UK – Health & Social Care Act 2003. Specifically, "Options for Change – a new vision of Primary Care Dentistry"

Its key features are similar

- Improve access
- Improve quality
- Improve oral health

To be achieved in the UK by re-siting commissioning of services to a local level to allow responsiveness to different community needs, increasing funding, improvement in services – quantity and quality issues, improving information.
Primary care treatment service orientated document.

European – WHO, Health 21 1998.
Policy and targets for European health in 21st Century

6. THE PRESENT POSITION

6.1 Oral Health in Jersey

Results of recent epidemiology in Jersey reflect situations found elsewhere in the developed world
Main findings

- although generally better oral health than UK as shown by comparable studies, within Jersey - very varied disease levels between population sub-groups; linked with social and economic factors. This applies to all ages surveyed.
- Although treatment levels for 14 year olds and below are greater than in UK, there are also disparities in active, untreated disease levels within the population in Jersey linked to social and economic factors
- Trend in oral health of five year old Jersey children has been towards improvement 1987-2002, 2004 has seen a reversal of this
- Oral health of Jersey residents over-65 would appear to be better than counterparts in UK as described by quantitative indicators. However, much unexpressed treatment need; again, disparities in oral health and access of care influenced by complex range of economic, lifestyle, belief, physical and general health factors.

Illustrations of epidem – five year olds dmft and % with decay experience 1987-2004; five year olds average decay experience by school and by component dt, mt, ft 2004.
(Appendix – Epidemiology [as circulated to group but with update for most recent 2004 5 year olds])

6.2 Oral Care Treatment Services in Jersey

Primary Care

a) Private Sector dentistry

- Self-funded businesses
- Excellent practitioner to patient ratio – 1:1500 (UK 1: 2700)
- Numbers regulated by residential qualifications
- Dentists from both UK and international origin
- professional matters addressed by Jersey Dental Association [are all practising dentists members??]
- requirements for registration to practice in Jersey [...help, please!.]
- costs incurred to patient
- JDFS help for 11-18
- Help for low-income over 65's
- Some practices operate insurance schemes e.g. Denplan

b) Hospital based Community Dental Service
[Brief profile of present service]

- salaried Civil Servants
- recruitment difficulties
- small establishment of dentists therefore level of service available is extremely sensitive to staffing considerations e.g. as indicated by waiting times between appointments,
- mainly patients under 11 - patients qualify to receive treatment by age not by disease level or economic criteria
- ad hoc services for special needs and residential/ nursing homes
- Presently demand-led
- Free to user
- Moderate range of treatments, budgetary constraints

Secondary Care

a) Hospital – based Orthodontic speciality

- free treatment, selected by treatment need – i.e. severity of disorder as defined by well-defined professionally accepted criteria as used in UK (Index of Orthodontic Treatment Need – IOTN)

b) Hospital-based Oral Surgery speciality

- referrals from GDP's for treatment of oral pathologies
- on-call for emergencies
- sedation facilities

b) Private sector provision
- some GDP's with special interest provide Orthodontic treatment for those not fulfilling the criteria for free Hospital care; patients pay
- some GDP's with special interest provide minor oral surgical procedures

Other Services

a) Screening
- State schools, annual. Blanket cover.
- Some screening of special needs children as resources allow (Mont A L'Abbe annually, Rouge Bouillon ad hoc)

b) Oral Health Promotion
- informal move towards targeting OHP to schools as indicated by epidemiology, but much provision is in response to external requests for input
- some input to carers in residential and nursing homes
- qualified members of staff – open university degree, diploma in OHP
- delivery and content of input not necessarily evidence based or proven effectiveness

Comment:

6.3 States Funding for Dental Services

Identify - Direct and indirect, H&SS committee, SS committee...[.....]
- Hospital – CDS, orthodontics, Oral Surgery services
- Health Promotion
- Dental Public Health
- JDFS
- Over 65's scheme
- Prison budget for inmates
- Parish welfare
- Some Civil Servants' pay-packet "allowances" – Police, Fire & Prison
- Visitors
- Reciprocal agreement?

7. JERSEY – LOCAL CHALLENGES

7.1 Dental Treatment

Routine child dental care free from Hospital CD service regardless of family income level. Full treatment costs incurred at GDP, unlike UK where child dentistry is free. Hospital service is therefore generally a popular, heavily-subscribed option. Would be difficult politically to reduce or introduce selection.

Adults under retirement age are liable for full cost of treatment, unlike UK where NHS costs are subsidised. Some parish welfare money available for cases of hardship – is this a socially acceptable system for many people? This expense may encourage patients to choose a treatment because of its lesser cost rather than its appropriateness for oral health. HIE exists for general health care but does not include dentistry.

Adults over 65 have a scheme for those who are on a low income to help with dental care costs; however, a recent dental survey demonstrated that this section of the community (especially the elderly females living alone who felt very socially isolated) gave dental attendance a low priority, still struggled with the cost of full dentures and had a strong attitude of "shut up and put up" regarding oral problems.

7.2 Dental Professionals

Although within the private sector, the ratio of population to dentist is extremely favourable, the Hospital CD department has historically struggled to recruit dental officers, and often has to look outside the island. Residency restrictions associated with these posts have complicated the situation, and the department has frequently had to employ a series of locum dentists who only remain for short periods.

- difficult to mould a team with united goals
- lack of continuity of care for child patients
- unfilled posts or extended absences mean treatment levels reduced and waiting times extend

Within a small CDS staff, cannot always possess the range of specialist expertise which would be desirable e.g Intra-venous sedation

- training issues – normally off-island and costly; often requirements of training involve the completion of a certain number of cases which may not be achievable on island
- cost investment vs historical employment-mobile nature of CD staff
- any "specialised" services established are very sensitive to staff changes
- difficulties of "buying in" services from private sector or off-island if a full-time speciality unsustainable

7.3 Population Size

Although there are difficulties outlined above in providing a broad-based service, however a small, contained population could be an advantage

- easier to investigate local health issues
- initiatives could be easier to implement and monitor
- policy makers "nearer to the ground"
- social infrastructure well-defined e.g. parish system

or a disadvantage

- pressure groups can be very powerful e.g as seen during the implementation of the over 65's scheme

7.4 Social issues

Population flow

- immigration – may involve cultural and language differences 17% of those arriving over the past 5 years were from Portugal or Madiera (excl short term seasonal workers)
- immigration – 6.4% population (excl seasonal workers) is Portuguese or Madeiran; 1.6% of the population speak no English
- seasonal workers, approx 4000 per annum, many from Portugal, Madeira
- emigration - residents leaving to follow higher education or career opportunities

Economy

- has been very stable with low unemployment but signs of unfavourable economic changes reflecting in decreased public spending and increasing constraints on public sector funding

Personal

- other economic pressures on the individual – personal hardship; *Jersey Health Survey 1999* those slightly above benefit threshold in great need of support for health services which incur a cost e.g. dentistry

7.5 Health and Social care arrangements

- strong involvement of charitable and voluntary organisations e.g nursing and home care
- parish welfare

8 ASSUMPTIONS

The following Strategic planning assumes

- funding at least remains stable in real terms i.e. growth factor to cover pay awards and inflation, may not be any extra capital input, but no budgetary cuts
- existing staffing levels can be maintained and are not subject to substantial fluctuation from leaving/recruitment problems
- can source the expertise necessary to implement action plans
- can access any training in identified skills to implement action plans

9. FUTURE CHALLENGES FOR ORAL HEALTH IN JERSEY

9.1 Demographic Change

a) The aging population

Statistics show that longevity has increased in Jersey in the past twenty years, and population projections demonstrate that there will continue to be a rise in the proportion of older people in the population. Females predominate in the older age groups. This has consequences for service delivery

- increased infirmity
- increased dependency
- decreased mobility
- social issues – e.g. isolation
- treatment challenges - more difficult technically, more difficult due to medical problems and physical difficulties of older people in coping with dental treatment
- increased residential care
- increase in trying to maintain individual in own home with social support mechanisms

b) Population Growth and Flow

- birth rates have declined during the last ten years, increased population accounted for mainly by falling death rates
- net migration has slowed right down since the mid-90's

9.2 Economic Changes

- increasing costs of healthcare in Jersey as worldwide
- continued historic financial constraints of funding healthcare; effect of the stability of Jersey economy on States spending
- Reciprocal agreements – will this change with the UK NHS changes; may affect secondary and tertiary care more than primary care?

9.3 Oral Disease Changes

- 2004 epidemiology showed a trend towards an increase in dental decay in 5 year olds – is this indicative of all children, is it just a "blip"
- emergence of dental erosion as a new epidemic due to increased consumption of carbonated drinks
- oral cancer shown to be on the increase – fastest growing cancer statistic in UK, 17% in 4 years

9.4 Social and Lifestyle Changes

May all have an impact upon the priority given to dental attendance and oral care.

- increasing trend in divorced and separated adults (44% between 1991 and 2001)
- increasing trend in single-parent households (from 5% in 1996 to 7% in 2001)
- evidence of homeless people sleeping rough

There will be an effect on the incidence of general health problems and oral disorders such as oral cancer from

- smoking and alcohol abuse (increase in UK)
- aggressive marketing of unhealthy dietary products - looks set to continue causing not only poor oral health but obesity and nutritional disorders

Also affecting general health but also consequences for infection control in the clinical environment and waste disposal – HIV, AIDS, Hepatitis B & C, CJD

- drug culture (increasing in UK)

9.5 Professional Developments

- effects upon dentistry from NHS Modernisation – opportunity to cherry-pick best practice etc
- compulsory registration of all dental team in pipeline in UK

9.6 Other legislative events in UK

These changes may have consequences for Jersey

- changes to the Dentists Act to allow GDC reform – proposed 2005
- Water Act 2003 – will this raise the profile of fluoride as a preventive measure (not necessarily in drinking water)
- Disability Discrimination Act 2004 – will dental service providers in Jersey be bound to make reasonable provision to their practices to allow the same access for disabled people as for able-bodied? This would have major impact upon GDP's
- DDA 2004 – consequences for employment

10. STRATEGIC PRINCIPLES

improvement in Oral Health will be achieved by addressing key themes

- improving access to treatment
- strengthening oral health promotion, prevention and public information
- nurturing co-ordination between Community and Private sector dentistry
- widening "shared-care" with outside providers and agencies and ensure dentistry is involved in the "joined-up" approach to health and social welfare

Underpinning principles

- patient-centred care
- holistic approach to care and messages
- importance of individual's responsibility for self-care
- strategic actions based upon assessed need
- use of cost-effective, evidence-based proven treatments and initiatives wherever possible
- development of quality and professional standards from within the profession
- incorporation of high quality safety net of regulation to protect the consumer
- education, training and personal development of dental team
- maximising potential of skill mix in light of expanded duties of Professionals Complementary to Dentistry (PCD)
- development and understanding of common objectives within team
- skill mixes should reflect strategic aims; maximise potential of all staff members with education and training.
- investment in IT and proven dental technologies
- acknowledgement of value of public contribution
- health monitoring by commitment to programme of research and epidemiology

11. FUTURE SERVICE DELIVERY CONSIDERATIONS

Oral health can be divided into 5 main elements

- treatment services
- preventive activity
- oral health promotion
- advisory and facilitatory
- dental public health (DPH) inc. epidemiology

Main deliverers

- Private dentists
- CDS
- Health promotion unit
- "bought-in" DPH expertise via CDS

The CDS

-is a small service with limited human and budgetary resource; it is very sensitive to both short and longer term staffing level fluctuations. Any strategic plans should have an inbuilt contingency for this and avoid the scenario where new schemes struggle due to sudden changes in staff availability.

-as a public health service it should focus upon the areas of greatest need; it should shift from demand-led to pro-active activity

-should be looking for opportunities to integrate oral care with GDP's

11.1 Priority groups

Aims of H&SS Committee to prioritise "the vulnerable, frail and the greatest need". The priority groups identified are

- children at high risk of developing dental disease
- children under age 11
- children over 11 from low income backgrounds
- children from socially-disrupted backgrounds
- adults and children with special needs
- institutionally bound people in both States-funded and Privately funded accommodation
- free-living over-65's on low income
- people of all ages with a true dental phobia
- poverty groups

11.2 Services

CDS should deliver on site and in the community

- basic routine dental treatments
- Oral Health Promotion schemes
- dental extractions under General Anaesthesia for children
- appropriate sedation and GA facilities for patients who cannot cope with treatment whilst conscious
- limited targeted screening programmes
- preventive treatments

In addition, the Hospital service will maintain its Orthodontic and Oral Surgery departments. This would include an out-of-hours emergency facility as at present.

STRUCTURE OF STRATEGY

To structure the Strategic framework, the following 5 key areas will be examined

- Oral health service delivery to priority groups (Sect 12)
- Oral Health Promotion (Sect 13)
- Community wide preventive initiatives (Sect 14)
- Epidemiology, research, DPH (Sect 15)
- Quality issues (Sect 16)

12. STRATEGY FOR IMPROVING ORAL HEALTH FOR PRIORITY GROUPS

12.1 CHILDREN

Introduction

It is important to promote positive oral health beliefs, behaviour and healthy dietary habits in the lifestyle of youngsters; this will not only help to prevent childhood dental problems, but maintain good oral health during adulthood. It is also essential that treatment services are available when required, especially for younger children who are dependent upon others to access care for them. Many children can achieve these two necessities with the support of their families and by accessing primary care in the Private sector; but specific groups of children have been identified within the population who are suffering poor dental health and would benefit from a more pro-active approach from the profession.

Priority groups

- children under 11
- children over 11 from low-income families
- children at high risk of developing dental disease
- children with disabilities
- children from socially disrupted backgrounds

The Problem

Background

Over the last five years, surveys of the dental health of Jersey schoolchildren have been performed in line with UK standards. When the overall population is considered, results have demonstrated a good standard of oral health when compared with most areas of the UK mainland; there is a moderately low incidence of dental decay with a high proportion of the disease having been treated. However, when different population sub-groups (as represented by individual schools) are examined, surprisingly large disparities are revealed; this is evident in both young children and teenagers. The discrepancies between schools can be associated with the affluence of the families who attend; broadly speaking, there is a "health gradient" with State schools at one extreme and Private schools at the other.

Socio-economic and Cultural Factors

The link between general and dental health and socio-economic status is well-established in research in the UK and rest of the developed world. It is also recognised that this link is not simply economic, but is influenced by a package of different value systems, beliefs, codes and mores which need to be accounted for in attempting to improve the health outcome.

Much research in the UK, particularly in the inner cities, has highlighted the influence of cultural and racial factors on health. For recent immigrants, difficulties of living in an alien environment, language problems, cultural influences upon behaviour and diet can have ultimate effects upon health and well-being. Although the Jersey dental surveys have not looked specifically at these residents, there is much anecdotal evidence within the Dental Department of poor dental health amongst younger Portuguese children.

Dietary Factors

Poor diet, especially a high intake of refined sugars, has been repeatedly shown to be associated with dental decay. Often due to financial and time limitations, or just plain lack of knowledge, the quality of nutrition amongst children from deprived homes is more likely to be poor, and the diet is also likely to be supplemented by unhealthy snacks. Children are often sent out without breakfast, and fill up on long-lasting cheap sugar-rich snacks and carbonated drinks all of which are highly cariogenic. Commercial marketing of sweets and unhealthy snacks directed specifically at children is at an all-time high.

Oral Hygiene Behaviour

Fluoride has been proven as a highly effective protection against tooth decay, and as Jersey has a very low concentration in the drinking water, regular application of toothpaste during brushing is important as the vehicle by which fluoride can strengthen enamel. However, those who do not clean their teeth regularly will miss this benefit; unfortunately, it has been shown that those from lower-income homes are less likely to adopt frequent toothbrushing routines. This may be due to lack of understanding, low priority of oral hygiene within the value system, or simply lack of paste, brush and facilities.

Uptake of Treatment Services

Many of the pupils at Private schools prefer to attend Private dentists, and will visit regularly. Amongst the State pupils the uptake is very variable, even though treatment for under-11's at the Community Dental Department is free; attendance patterns are less regular, many preferring to attend with pain or a problem rather than for a check-up.

Those over the age of 11 from families on low income can register for subsidised treatment with the JDFS; registration with the JDFS is 1465 as at September 2003. A recent questionnaire to parents of 12 and 14 year olds revealed problems with the JDFS related to the cost of registering multiple children, lack of knowledge of the Scheme and apathy towards registering; also frequently mentioned was the income threshold being too low.

Children with a disability, chronic health problems or from socially disrupted backgrounds

These children may require a high level of dental maintenance because their medical conditions have physical consequences upon the oral cavity or because they simply cannot perform the oral hygiene activities effectively and are thus more prone to problems. Many medications also have deleterious side effects upon the teeth and gums. In addition, their conditions may complicate what might be otherwise simple treatment; clinicians need to have the skills to deal with these diverse conditions and also have specialised equipment and facilities if necessary. Prevention of oral problems is therefore of paramount importance.

Ideally, it would be introduce these children to regular dental attendance early, but Dentistry may be a low priority for the families, and the child may not make contact with dental services until a crisis occurs. In this event, families and carers need to know how and where to access treatment speedily. The system should then ensure regular monitoring of their oral health through recall appointments.

Aims

The aims relating to child oral health are

- Address inequalities in child dental health by targeting high-risk population groups as identified by epidemiology.
- Maintain treatment services for those who are under 11, who wish to access primary care at the Community Dental Department.
- Assess Jersey Dental Fitness Scheme for those over 11 years of age in light of possible developments in benefit structure as a whole; if it continues, it will still be accessed via the Private sector and uptake will be promoted.
- Help achieve good oral health for children with a disability, chronic health problems.
- Help achieve good oral health for children from socially disrupted backgrounds.

AIM 1.1 Address inequalities in child dental health by targeting high-risk population groups as identified by epidemiology

ACTION	RESPONSIBILITY	CONSULTATION	PLANNING TIMESCALE
1.1.1. Formulate Oral Health Promotion Strategy	HP, CDS, DPH	Other health professionals, schools, communities and other agencies	2005-6
1.1.2 Formulate plan of Preventive Strategies to include community and clinical delivery (particularly inc Fluoride)	CDS, HP, DPH	Other health professionals, schools, communities and other agencies	2005-6
1.1.3 Explore ways to improve dental health of Portuguese and other immigrant children	CDS, HP, DPH	Relevant community leaders, other health professionals, schools, other agencies	2005-6
1.1.4 Monitor dental health with regular surveys	CDS, DPH		Ongoing
1.1.5 Ensure screening plan is targeted on schools with poor dental health (ensure those not screened are reminded to access dental checks regularly)	CDS	Schools	2005

AIM 1.2. Maintain treatment services for under 11's, who wish to access primary care at the Community Dental Department

ACTION	RESPONSIBILITY	CONSULTATION	PLANNING TIMESCALE
1.2.1 Continue to provide treatment services at present level for under 11's	CDS		Ongoing
1.2.2 Examine working practices inc materials used to ensure treatment delivery effective and efficient	CDS		2005-2006
1.2.3 Review types of treatment offered in CDS	CDS		2005-2006

AIM 1.3. Assess Jersey Dental Fitness Scheme

ACTION	RESPONSIBILITY	CONSULTATION	PLANNING TIMESCALE
1.3.1 Ensure appropriateness and acceptability of scheme	CDS, ESS	ESS	In line with ESS timetable
1.3.2 Ensure cost-effectiveness of scheme	CDS, ESS	ESS	In line with ESS timetable
1.3.3 Dependent upon ultimate benefit structures – promote uptake of JDFS	CDS, ESS	ESS, PD's, focus groups, administrators of scheme	In line with ESS timetable
1.3.4 Dependent upon ultimate benefit structures – ensure over 11's from low income families can and do access affordable dental care	CDS, ESS	ESS, PD's, focus groups	In line with ESS timetable

AIM 1.4. Help children with a disability or chronic health problems to achieve good oral health

ACTION	RESPONSIBILITY	CONSULTATION	PLANNING TIMESCALE
1.4.1 Needs assessment studies of this client group – either local or extrapolate from e.g UK	CDS, DPH	Parents, GP's, nursing, carers, Social Services,	2005-2006
1.4.2 OHP Strategy to include delivery to these children, families and carers	HP, CDS	Parents, GP's, nursing, carers, Social Services	2005-6
1.4.3 Deliver preventive support to these children, families and carers	CDS, HP, DPH	Parents, GP's, nursing, carers, Social Services	2006-
1.4.4 Explore methods to expedite referral to dental services (CDS or PD)	CDS	Parents, GP's, carers, SS, PD's, nursing	2005-6
1.4.5 Maintain regular dental attendance during childhood and into adulthood	CDS, PD's	Parents, GP's, carers, SS, PD's, nursing	2005-6
1.4.6 Ensure staff receive necessary training and support to treat these children	CDS	Community Dental Officers (CDO's), PD's, JDA	ongoing
1.4.7 Ensure Hospital facilities are in place for treatment inc sedation and GA and are available within a reasonable time	CDS	Hospital management, anaesthetists, nursing, GP's	ongoing
1.4.8 Ensure oral damage limitation regarding long-term medication	CDS,	HP, GP's other health professionals	2005

AIM 1.5. Help children and adolescents from socially disrupted backgrounds to achieve good oral health

ACTION	RESPONSIBILITY	CONSULTATION	PLANNING TIMESCALE
1.5.1 Assessment of need	CDS, DPH	Social Services, carers, residential homes' staff, Children's service	2006
1.5.1 Establish "fast-track" referral mechanism for accessing treatment and ensure that appropriate agencies and carers are aware	CDS	Social Services, carers, residential homes' staff, Children's service	2006
1.5.2 Establish method for sensitive and confidential passage of relevant information from Social Services/ Children's Service to ensure that regular care is maintained even if child is moved	CDS	Social Services, carers, residential homes' staff, Children's service	2006
1.5.3 Draw up policy for recognition and action in cases of suspected abuse and non-accidental trauma	CDS	Professional orgs, CDS staff	2006

12.2 ADULTS UNDER 65

Introduction

There is virtually no information specifically relating to Jersey about the oral care needs of this age group. However, the Adult Dental Health Surveys performed in the UK have shown that oral health in the general adult population has improved considerably over the past 3 decades. There is every reason to believe that this would be reflected in the population of Jersey. However, as seen in the child population, there are considerable inequalities relating to social and economic issues.

In a climate of solely private care for routine dental treatment, it could be assumed that the expense of treatment would be a demotivating factor to the poorer sections of this part of the population. There is commentary evidence from the questionnaires completed by parents of the children involved in the annual surveys to support this.

Research in the UK has shown that disabled and chronically ill adults have problems in finding dental care because of lack of information, inaccessible premises, transport difficulties and inadequate facilities or expertise available in the general dental services.

The priority groups identified relating to adult dental health are

- Low-income adults
- Adults with a disability
- Patients with a genuine phobia of dental treatment

The aims relating to adult oral health are

- Improve access to dental services for low-income adults
- Ease the burden of costs of dental treatment for low-income adults
- Improve access to dental services and oral care for special needs adults
- Explore provision of treatment service for phobic patients

AIM 2.1 Improve access to treatment for low-income adults under 65

ACTION	RESPONSIBILITY	CONSULTATION	PLANNING TIMESCALE
2.1.1 Improve information about dental services available - e.g locations, special dental interests of PD's	CDS, PD's	PD's, JDA	2005
2.1.2 Involve this group in OHP strategy – informative and awareness raising e.g. smoking and oral cancer	CDS, HP, PD's	PD's, JDA	2005
2.1.3 Formal publicity to special awareness campaigns e,g, no smoking day, oral cancer week	CDS, HP, PD's	PD's, JDA, other health professionals, community targets, workplaces media	ongoing
2.1.4 Research oral health and associated dental attitudes of this amorphous group	CDS, DPH	Focus groups	2005-6
2.1.5 Explore the viability of providing a telephone "helpline" to advise public on finding a dentist	CDS	CDS, Hospital management	2005-6

AIM 2.2 Ease the burden of costs of dental treatment for low-income adults under 65

ACTION	RESPONSIBILITY	CONSULTATION	PLANNING TIMESCALE
2.2.1 Investigate parish welfare system in connection with help with dental treatment costs	CDS	PD's, connetables	2005-6
2.2.2 Investigate other payment schemes e.g. denplan-type	CDS, PD's	PD's, insurance scheme experts	2005-6
2.2.3 Ensure that "allowance" is made for help with dental treatment in any new benefit / welfare structure	CDS, ESS	ESS	In line with ESS timetable

AIM 2.3 Improve access to care for special needs adults

a) for those able to cope with treatment in Private sector dental locations

ACTION	RESPONSIBILITY	CONSULTATION	PLANNING TIMESCALE
2.3.1 Ensure adequate information on services is readily available for patients and carers and actively promoted (inc disabled access to premises)	CDS, PD's	PD's	2005
2.3.2 Investigate transport possibilities for disabled people and ensure awareness of availability	CDS	Transport providers – public and private	2005-
2.3.3 Investigate schemes for help with transport and/or costs	CDS,ESS	ESS, SS	2005-
2.3.4 Ensure support for PD's caring for their patients with disabilities inc specialist advice and services, and training if nec	CDS, PD's	PD's, Hospital management anaesthetists, nursing, GP's	2005-

b)) for those not able to cope with treatment in Private sector dental locations

ACTION	RESPONSIBILITY	CONSULTATION	PLANNING TIMESCALE
2.3.5 Set up formal mechanism for referral of disabled adults to CDS	CDS	Carers, Social Services, GP's, other health professionals, other agencies	2006
2.3.6 Ensure adequate services are readily available in the Hospital for treatment e.g GA	CDS	Hospital manage-ment, anaesthetists, nursing, GP's	2005
2.3.7 Provide CDS staff with adequate support and training to treat this client group	CDS	CDO's	2005-6
2.3.8 Ensure CD department facilities are suitable for access and treatment inc privacy	CDS	Hospital management	Ongoing with relocation to new community dental premises
2.3.9 Investigate transport possibilities for these patients and carers	CDS	Hospital transport, ambulance service	2005-

AIM 2.4 Explore provision of treatment for phobic patients

ACTION	RESPONSIBILITY	CONSULTATION	PLANNING TIMESCALE
2.4.1 Investigate the possibilities and practicalities of offering a limited treatment service for phobic patients – inc e.g. facilities, sedation, staff training, counselling/therapy, time implications	CDS	CDO's, hospital management,	2006-

12.3 ADULTS OVER 65

Introduction

There is evidence from both UK research and locally that older and elderly people have particular problems with oral care. A survey of people over 65 was conducted in Jersey in 2001, the results highlighted several problems relating to this population group, including

- Uptake of dental services declines with age.
- Medical problems, chronic illness and mobility difficulties increase with age.
- Although teeth are retained for longer than in the past, people find it increasingly difficult to maintain their teeth in good condition.

The Problem

Low Uptake of Oral Care Services

Cost

Many retired people find that their reduced income forces them to prioritise their funds, and often dentistry is placed low on the list. The perceived high cost of Private dentistry leads to a general decline in attendance even amongst those who would attend regularly prior to retirement. For those with a problem, there is not only a fear of the cost of treatment necessary to alleviate their trouble, but also of additional items which may be found to be needed.

Need for regular attendance is not understood

Regular attendance is considered less important as they have fewer or no remaining teeth, and fewer apparent problems. There is a poor appreciation of the benefits of dental care at their stage of life; it is not commonly understood that the incidence of potentially serious pathologies increases with age and therefore regular examination of the mouth is important even if no teeth are present.

Acceptance of the status quo

Many people interviewed for the Jersey survey of 2001 were either apathetic about attending a dentist or held the view that their present situation, although unsatisfactory, could not be improved; they preferred to "put up with it". There was a high prevalence of oral pathologies including dental decay, gum disease and soft tissue abnormalities; the latter, although mostly minor, could easily progress to more serious consequences. A high percentage of dentures were very old and ill-fitting, causing not only discomfort but actual damage to the oral tissues. Even amongst those who would be perceived as "well able to afford it" there is a reluctance to attend until circumstances dictated.

Practical Difficulties

The increase in living alone is an aspect of the aging population; the ratio of females to males also increases with age. Lack of knowledge of how and where to access dental care, lack of transport, feelings of helplessness and isolation all present barriers to attendance.

Medical problems, Chronic Illnesses, Physical Limitations

Medical Problems and Oral Health

Medication for general health problems is more prolific in this age group, and many drugs have side-effects upon the mouth. These include reduction in saliva flow and increased frequency of sugar ingestion, due to the syrup bases of some liquid medicines; these factors predispose to dental decay and gum disease, and also poor retention of dentures.

Medical Problems in General

More elderly people experience medical problems which impair their physical mobility. In addition to finding it difficult to get around and attend appointments, they are unable to utilise many dental surgeries which have no ground floor access or disabled facilities.

Prolonged Retention of Natural Teeth

The UK studies of Adult Dental Health have shown an increase in the proportion of people retaining their natural teeth to an advanced age. Although this is one of the success stories of modern dentistry, the maintenance of good oral health becomes more challenging with age. Physical limitations may decrease the frequency or efficiency of cleaning practices; those who have complex conservation in the past may find it impossible to care adequately for these intricate restorations. The cost of repair of these items can also prove to be beyond their means due to reduced income after retirement.

The restoration of the elderly dentition also presents challenges to the skill of both clinicians and patients. Treatments may become more complicated and time consuming, and harder for elderly patients to endure. All these factors may result in the eventual loss of teeth despite every effort.

Priority groups

The priority groups identified for this age group are

- Those aged over 65 on low incomes
- Those aged over 65 who are in residential or nursing homes
- Those aged over 65 who are housebound

Those on Low Income in their own homes

The 65+ dental health plan has been recently introduced to help with the expense of dental treatment. Although the recent survey of older people has established a need for treatment expressed by both professionals and the public themselves, registration has been disappointing. It may be however, that people are not registering until they "need it".

Older people who are housebound or Institutionally bound

This covers a vast range of individual circumstances and abilities, but a commonly found problem is access to regular and emergency dental care. The CDS and some Private Dentists provide treatment on an ad hoc basis at present, most would be on an irregular or emergency basis. Little more than anecdotal evidence exists of the oral health needs of people in Jersey's residential or nursing homes, but the recent survey of older people included those in their own homes who were severely restricted in their mobility. Not only was there a lack of knowledge of how to access dental care, but also, of greater concern, a strong feeling of general isolation and exclusion. Regular examinations may be of very low priority to those in these circumstances, but an easy, friendly and swift access to advice or help for their dental problems would be of great value.

It is strongly felt that many care staff in residential or nursing homes often have poor knowledge of oral care for their elderly and sometimes very frail charges, and would benefit from training. This concern is frequently expressed by many carers themselves who are worried that they may be negligent or even causing harm with inadequate oral hygiene procedures. People in their own homes may also need advice on self-care e.g. they may be unaware of the existence of oral hygiene aids designed for those who struggle with decreased manual dexterity.

The aims relating to the oral health of people over 65 are

- Improve access to dental services for low-income adults over 65
- Ease the burden of costs of dental treatment for low-income adults over 65
- Improve dental services for people over 65 in residential and nursing homes
- Improve access to dental services for people over 65 who are housebound

AIM 3.1 Improve access to dental services for low-income adults over 65

ACTION	RESPONSIBILITY	CONSULTATION	PLANNING TIMESCALE
3.1.1 Investigate perceived needs of this group in terms of treatment and service	CDS, DPH	Focus groups, agencies representing client group	2006-
3.1.2 Explore viability of providing basic pain relief service from Hospital with a view to directing patient to PD services	CDS	Hospital management	2006-
3.1.3. Improve availability of information regarding PD's practices and special dental interests	CDS, PD's	PD's JDA	2005
3.1.4 Explore the viability of providing a telephone "helpline" to advise public on finding a dentist	CDS	CDS, Hospital mangement	2005
3.1.5 Ensure effective dissemination of relevant public info on oral matters e.g. oral cancer	CDS, HP		ongoing
3.1.6 Ensure oral damage limitation regarding long-term medication	CDS	HP, GP's other health professionals, carers	2005-

AIM 3.2 Ease the burden of costs of dental treatment for low-income adults over 65

ACTION	RESONSIBILITY	CONSULTATION	PLANNING TIMESCALE
3.2.1 Evaluate Jersey 65+ Health Plan with ref to oral care-	CDS, ESS	ESS	In line with ESS timetable
3.2.2 In the interim, look at ways of improving uptake of 65+ scheme	CDS, ESS	ESS,	In line with ESS timetable
3.2.3 Investigate role of Parish welfare in dental treatment for this group – its usage and appropriateness	CDS	Connetables	2005-

AIM 3.3 Improve dental services for people over 65 in residential and nursing homes

ACTION	RESPONSIBILTY	CONSULTATION	PLANNING TIMESCALE
3.1.1 Investigate needs of this group in terms of treatment and service	CDS, DPH	Focus groups, agencies representing client group	2005-
3.3.2 Formulate screening programme	CDS	CDO's, homes	2006-
3.3.3 Formalise protocol for referral and treatment	CDS, PD's(?)	CDO's, PD's (?), homes	2006-
3.3.4 Implement regular OH education programme for carers bearing in mind high turnover rate of staff	CDS	CDS, homes	2005-
3.3.5 Ensure Hospital facilities are appropriate and readily available (inc possible access to theatre within reasonable time) for treatment if necessary	CDS	CDO's, Hospital management	2005

AIM 3.4 Improve access to treatment for people over 65 who are housebound

ACTION	RESPONSIBILITY	CONSULTATION	PLANNING TIMESCALE
3.4.1 Investigate perceived needs of this group in terms of treatment and service	CDS, DPH	Focus groups, agencies representing client group	2005-
3.4.2 Formalise protocol for referral and treatment	CDS, PD's	CDO's, PD's, focus group, carers, GP's, nursing, Social Services	2006-7
3.4.3 Investigate transport possibilities and help with costs	CDS	Hospital management, SS, ESS	2005-6
3.4.4 Explore the viability of providing a telephone "helpline" to advise public on finding a dentist	CDS	CDS, Hosptial management	2005
3.4.5 Work with carers and other informative agencies (e.g. media) to increase awareness of home oral self-care inc. OH aids	CDS, HP	Carers, voluntary agencies, media	2006
3.4.6 Ensure housebound are not excluded from oral health awareness campaigns e.g oral cancer week	CDS, HP	Media	ongoing

13. ORAL HEALTH PROMOTION STRATEGY

An Oral Health Promotion Strategy is vital not only for improving the oral health of the priority groups as described above, but would also have elements aimed at the wider community. There are also opportunities for incorporating dental messages into the Health Promotion Strategy, reinforcing for mutual benefit the common messages, with regard to e.g. dietary and nutritional themes, smoking, alcohol, cancer awareness, accident prevention.

[For detailed development between CDS, DPH, HP – 2004/5]

14. STRATEGY OF PREVENTIVE INITIATIVES

Exploring opportunities for improving oral health using a combination of high-risk strategies as referred to above, and population approaches.
It would feature a number of evidence based proven community initiatives (as opposed to individual treatment plans), gathered from schemes tried and found effective in the UK and elsewhere.
It would include programmes involving

- fluoride in its many applications
- preventive treatments such as fissure sealants
- oral hygiene practices
- education

[For detailed development CDS, DPH 2004/5]

15. STRATEGY FOR RESEARCH, EPIDEMIOLOGY AND DENTAL PUBLIC HEALTH

Including

- local oral health data collection regarding various population groups in order to provide benchmarks for evaluation and development of indicators
- regular, comparable monitoring of population oral health

[For detailed development 2004/5]

16. QUALITY STRATEGY

Aiming for a profession delivering consistently high quality services in which patients can feel confident and reassured.
There will already be local ways of addressing local professional issues, and practices of a high standard; however, there may be gaps or need for change in the light of GDC reforms etc. Protocols for procedures, responsibilities and accountabilities need to be laid down formally, preferably self-driven by respected representative professional body such as JDA.
Local mechanisms can be developed from within the profession, cherry picking best practice and standards from the changes occurring in UK dentistry, and integrating them with professional regulation as prescribed by the GDC.

Involving formalising approaches to

Professional issues

- Clinical audit
- Peer Review
- Quality standards
- Clinical Governance see 17 below
- Continuing Professional Development (CPD) and re-registration
- Registration of Professionals Complementary to Dentistry (PCD's)

Protecting patients

- improving information for patients on treatment
- safe and clinically effective treatments – NICE, clinical pathways
- clarifying first-line complaints mechanisms
- requests for advice e.g. parish welfare,

Best use of Professional Skills

- maximise education, training and development of whole dental team
- maximising the expertise within the island, through co-operation and information sharing

[For detailed development 2005-]

17. CLINICAL GOVERNANCE

UK Department of Health defined clinical governance as 'a framework through which NHS organisations are accountable for continuously improving the quality and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish' (A First Class Service DOH 1998)

Although CG and quality have many commonalities, their differing territories warrant separate consideration. The term CG brings together many activities already in place into a more formally stated requirement. Some of the elements addressed by CG -

- clinical audit
- risk management
- evidence-based practice
- patient input
- clinical supervision
- clinical leadership
- continuing educational and professional development
- management of poor performance
- team building
- peer review

Both State-funded and Private Sector professionals should embrace CG but there are obvious local difficulties particularly involving the Private services

- some may decline involvement, not understanding their role in CG
- developing CG requires investment of time, this time may be perceived as economically unproductive in the short term; as it is a long-term commitment, practice owners may feel that this is financially non-viable
- there is no formal requirement for participation or penalty for non-involvement.

These are real barriers to development of CG in a predominantly Private marketplace, and need to be addressed from both professional and political standpoints e.g.

- CG should be included in JDA proceedings
- Could be integrated with CPD?
- Understanding of the professional responsibility for the ethos of CG should be carefully and sensitively delivered to both private and public dental services in an atmosphere of consultation and co-operation
- Protocols for the management of poor performance, complaints and disciplinary matters should be formalised – especially the concept of a panel of wise-(wo)men from within the profession in Jersey
- Professional lines of accountability should be formalised; it may be necessary to examine the terms under which registration to practice on the Island are defined – are the responsibilities of the professional individual towards the States and the public stated explicitly enough?
- Incentives (other than directly financial) could be explored – e.g. accreditation scheme which would give a practice a perceived "marketing edge" in the public eye?

The BDA have developed a package to assist dental teams to address CG – this, along with NHS models could be used as background support for work on this issue.

Jersey has recently been exploring CG with the medical professionals – are there any positive lessons which could be adopted in the dental negotiations?

18. FUNDING AND RESOURCE ISSUES

Financial implications

The above projects will have to be worked on in a neutral cost environment, as new funding is unlikely. This would apply to the budgets of both Health and any other States departments involved in these projects. Other caches of funding have been identified above (6.3) but are not accessible at present. (It may be of value to investigate these sources further during the strategic process).

Human resource

At present, there are about 800 clinical sessions of a dental officer with supporting staff available on an annual basis. The new dental department opened in the summer of 2004 and has more clinical space available; this will allow the number of sessions for diagnosis and treatment of dental problems to increase to about 900 per year.

In 2002, this was allocated as follows

680 clinical sessions on treatment of under 11's
30 screening sessions
90 other activities

There were 84 sessions of Oral Health Promotion by a dental nurse who has a qualification in Oral Health Promotion

It is unlikely that this profile will be substantially different in the foreseeable future because

No increase in funding is expected
Recruitment is a particularly difficult issue

Thus, resources for new undertakings need to be found from internal savings and redeployment.

Costs

Some of the underlying principles to be borne in mind during the planning process are

- Materials and equipment to treat priority groups to be found from existing budget
- Oral Health Promotion materials to be obtained wherever possible from dental companies and sponsorship
- Treatments provided to priority groups other than children should wherever possible be undertaken by Private sector.
- A list of charges should be drawn up for treatments (e.g. dentures) provided by CDS prior to commencement of services to adults. The charges must cover the costs but be affordable to low-income patients
- Any treatment provided by the CDS, or associated costs, should be funded by the patient or usual support system (Social Services, over 65 scheme etc) according to the CDS scale of charges.

18(a). BEST SPENDING?

Although it is imperative that the Strategy addresses the efficiency with which the public sector funding is utilised by the service provider at present, it is necessary to look at the broader issue of whether the type of services provided represent the best usage of States resources. However, the critical analysis is not solely one of cost-effectiveness but balances this with practicality and acceptability.

The total States dental budget covers activities broadly divided into three areas – Oral Surgery, Orthodontics and Community Dental Services.

Oral Surgery

- highly specialised, both personnel and equipment
- level of expertise cannot be sourced in the high street
- demand-led for health reasons
- (excluding minor cases) Hospital-based for many reasons
- some off-island treatments

Because demand for this element of the service is dictated by largely uncontrollable events (e.g. disease incidence, trauma) the service level must be maintained.

Orthodontics

- specialised
- more availability in the high street
- complex cases necessitate Hospital-based attention
- demand for Ortho in general is stimulated for both health and cosmetic reasons

Cases for treatment within the Hospital department are already selected using the Index of Treatment Need (IOTN). This is a tool for grading the health impact of an individual's dental malocclusion; it is widely used in the UK. At present, the department only accepts individuals for treatment whose malocclusions are judged to have moderately severe to severe health implications by IOTN, it does not treat for purely cosmetic reasons. It would be difficult to justify application of more stringent selection criteria to the caseload.

However, as with CDS, there should be regular reviews of the "patient's journey" through the Oral Surgery and Orthodontics departments.

Community Dental Services

Could CDS activity be best acquired elsewhere? It makes sense for CDS to provide

- treatments under General Anaesthetic - *must* be Hospital-based
- treatment for client groups who would not seek care, or whose care requires extra time or expertise e.g. more severe disabilities
- "outreach" activities such as screening and Oral Health Promotion
  - would not be attractive to Private providers
  - OHP most effectively delivered by those with special training – available in the department
  - can be co-ordinated and directed over the population
- epidemiological activity
  - co-ordinated by CDS department
  - specialised
  - results used to direct resources from a central point

Routine treatment

The routine treatment of over-11's has been directed towards the private sector, some have proposed that all children's routine dental care be brought under the private umbrella within an extended JDFS scheme.
However, the JDFS has demonstrated shortcomings which could be significantly more deleterious to the oral health of younger children.
It is important to establish oral care behaviour and regular attendance at an early age. In order to support this, the existence of a managed, free service is crucial for certain groups in the younger population

- self-motivated attendance has been shown to be less likely amongst those who need it most, notably those from poorer backgrounds. As younger children generally rely on others to take them for dental care, those from disadvantaged homes would become even more vulnerable if the as their parents are less likely to attend regularly.
- The CDS has the responsibility and opportunity to identify and encourage these children to attend for care more effectively, private practice is predominantly demand-led
- Many disadvantaged families would be discouraged from seeking regular care if the service was not free of charge.
- It would be unlikely that additional funding would be available for an extension of the JDFS to cover younger age groups, either for subsidy of treatment costs or the not inconsiderable administration costs.
- It has been suggested that some families should pay for treatment based upon financial selection criteria. However, evidence implies that families from more economically favourable backgrounds tend to self-select to take their children to private services anyway. "Means testing" would be politically unpopular and administratively unwieldy to implement for little saving.

Private sector dentistry

It is perceived by many that private sector dental charges in Jersey are high when compared with the UK. However,

- The accusation of dentistry being over-expensive is not merely a local phenomenon, it is frequently levelled at the profession in the UK
- Comparison with NHS is misleading - NHS treatment is undergoing fundamental changes at the moment, and it is perceived by the profession that quality of care is being compromised by government underfunding. It is likely that costs to the public for treatment will be raised to a more "realistic" level.
- Practice overheads – including rents, services and staff salaries are higher locally
- Some laboratory items have to be sent off-island incurring extra costs

This issue of private sector fees is explored more fully in an excellent communication from Jonathan Wood to Jeremy Willetts June 2004 which was circulated to the Strategy Group. It also touched on local dental Manpower in Jersey and range of services. The opinions and statistics from this letter could be included here.
(Mike - I'm not sure if the sentiments expressed in this letter (June 16th 2004) are supported as the official line of the JDA – it would be helpful to check this out before we incorporate it into the Strategy)

19. TARGETS AND INDICATORS FOR ORAL HEALTH

Where appropriate, targets will be set and indicators of success will be included in the above action plans

20. SUMMARY OF AIMS AND TIMEFRAME

21. EXECUTIVE SUMMARY

22. APPENDICES

23. REFERENCES AND CONTRIBUTORS

17.1 ORAL HEALTH OF CHILDREN UNDER 11

Targets based upon results of 2004 survey of dental health of 5 year olds.

i. Decay Experience (dmft)

In 2004, the average dmft of Jersey 5-year olds was 1.10 (2002 – 0.81)

Target

Reverse the unfavourable trend seen between 2002-4, and continue the improvement seen in previous years to achieve a dmft for 5 year olds of 0.60

Timescale

Target date 2010. (Survey of 5-year olds due in this year).

ii. Decay Experience (percentage of 5-year olds experiencing decay)

In 2004, the proportion of 5-year olds who had experienced dental decay was 32% (2002 – 23%)

Target

Reverse the unfavourable trend seen between 2002-4, and reduce the percentage of 5 year olds who have experienced dental decay to 20%

Timescale

Target date 2010.

17.2 ORAL HEALTH OF CHILDREN AT HIGH RISK OF DENTAL DECAY

The four schools found to have the highest rate of dental decay in 2002 were Grands Vaux, Rouge Bouillon, Le Squez and St Mark's; these schools have consistently shown the worst dental health in previous surveys of 5-year olds.

i. Decay Experience (dmft)

In 2004, the mean dmft score of these four schools was 2.1 (2002 – 1.7).

Target

Reverse the unfavourable trend seen between 2002-4, continue the improvement seen in previous years to achieve a dmft for 5 year olds of 0.60

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Timescale

Target date 2010.

ii. Decay Experience (percentage of 5-year olds experiencing decay)

In 2004, the mean proportion of 5-year olds at these four schools who had experienced dental disease was 45%.

Target

Reduce the combined percentage of those who have experienced decay to 35% .

Timescale

Target date 2010.

9.1 Primary care treatment services
Team working - departmental

- development and understanding of common objectives
- analyse skill mixes and maximise potential of all staff members with education and training.
- Investigate further expanded duties of Professionals Complementary to Dentistry (PCD)