healthwatch
North Lincolnshire

Getting to the root of the issue

November 2024

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1 Introduction

1.1 Who are Healthwatch North Lincolnshire?

The Health and Social Care Act 2012 set an ambition to put people at the centre of Health and Social Care. This legislation created a Healthwatch in every local authority in England.

Healthwatch North Lincolnshire is the local independent consumer champion created to gather and represent the views of the public.

Healthwatch North Lincolnshire ensures that the views of those using services in North Lincolnshire are taken into account and used to influence and shape Health and Social care at a local and national level.

1.2 What is Enter and view?

Part of the local Healthwatch programme is to carry out Enter and view visits. Enter and view is the statutory power granted to every local Healthwatch which allows authorised representatives to observe how publicly funded health and social care services are being delivered.

Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being run and make recommendations for improvement.

The Health and Social Care Act allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies. Enter and view visits can happen if people tell Healthwatch there is a problem with a service, but equally they can occur when services have a good reputation, so Healthwatch can learn about and share examples of what they do well from the perspective of people who experience the service first hand.

Healthwatch North Lincolnshire use powers of enter and view to find out about the quality of services within North Lincolnshire.

Enter and view is not an inspection, it is a genuine opportunity to build positive relationships with local Health and Social Care providers and give service users an opportunity to give their views in order to improve service delivery.

Enter & View allows Healthwatch to:

- Observe the nature and quality of services
- Collect the views of service users (patients and residents) at the point of service delivery
- Collect the views of carers and relatives of service users
- Collate evidence-based feedback
- Enter and view can be announced or unannounced

Healthwatch Enter and Views visits are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit, they are reported in accordance with Healthwatch safeguarding policies. If at any time an authorised representative observes anything that they feel uncomfortable about they are instructed to inform their lead who will inform the service Manager, ending the visit.

In addition, if any member of Staff wishes to raise a safeguarding issue about their employer, they will be directed to the CQC where they are protected by legislation if they raise a concern.

2.3 Disclaimer

Please note that this report relates only to findings observed on the dates of the visits. The report does not represent the experiences of all service users and Staff, only an account of what was observed and contributed at the time. The findings are based upon the perceptions of those taking part, which are not verified for factual accuracy.

2 Background

2.1 Why this subject?

Good oral health is important for everyone, it can affect confidence and self-esteem, and it can also affect appearance and whether we choose to smile. Looking after our oral health can prevent pain, disease and certain cancers, as well as promoting self-confidence, and allowing us to continue eating the foods we love.[1]

However, achieving good oral health can be a challenge for some groups of individuals who may require extra help and support.

Adults over the age of 75 living in residential care are more likely to experience tooth decay than those living in their own home.[2] Older people are at greater risk of developing dental problems due to conditions such as Parkinson's disease and arthritis which makes brushing teeth more difficult and the use of medications that can cause a dry mouth.

Evidence has also shown that people with learning disabilities are more likely to experience dental problems such as gum disease, higher plaque levels and higher rates of untreated tooth decay. A lack of understanding of how to take care of teeth and a reliance on carers to support with dental visits are some of the factors contributing to this. [3]

In July 2016 The National Institute for Care Excellence (NICE) published the guidelines NG48 'Oral Health for adults in care homes' with the aim of ensuring that residents in care homes are receiving the correct support to maintaining good oral health and have access to dental services.

In June 2019 the Care Quality Commission published a report; 'Smiling Matters: Oral care in care homes' which looked at 100 residential care homes

[1] CQC, Smiling Matters
https://www.cqc.org.uk/sites/default/files/20190624_smiling_matters_full_report.pdf

[2] https://www.nice.org.uk/Media/Default/Oral_health_quick_guide/Oral_health_a_quick_guide_for_care_home_Managers.pdf

[3] https://www.gov.uk/government/publications/oral-care-and-people-with-learning-disabilities/oral-care-and-people-with-learning-disabilities#oral-health-of-people-with-learning-disabilities

[4] 'Smiling matters- Oral Care in Care Homes' Care Quality Commission

across the country to review oral health provision and look at whether the NICE guidelines were being adopted consistently.

From this, the CQC found that too many people living in care homes are not being supported with maintaining or improving their oral health. Over half of Care Homes did not have a policy that protected and promoted good oral health. Almost half of Staff working in care homes had not received oral health training and most of the care homes visited (73%) did not cover oral health in the resident's care plans. The CQC also found that it was difficult for residents to access routine dental care, and access to emergency care was also a challenge.[4]

In November 2019 Healthwatch completed their own project "Getting to the root of the issue"

We wanted to understand how people in care homes are supported with oral health, and what their access to dental services was like in North Lincolnshire.

We wanted to give local care home residents the opportunity to share their experiences of living in care home, and accessing dental care, and compare these experiences to those shared in the 'smiling matters' report.

Please see 2019 report

HW Guidane

2.2 Strategic drivers

In spring 2024 Healthwatch North Lincolnshire undertook a priorities survey, which continued to highlight an issue with access to dental services in Northern Lincolnshire.

In August 2024 Healthwatch received 15 experiences regarding dentistry from our engagement with the public. The theme from the feedback received is the lack of appointments and long waiting lists for the people of North Lincolnshire.

The feedback from this survey in conjunction with the project completed in 2019 prompted Healthwatch to revisit the project to see if there had been further developments and improvements in the care homes we visited in 2019 over the following 5-year period.

The NHS dental recovery plan was released in February 2024. Published under the previous Conservative government, the plan set out a number of initiatives aimed at tackling access issues within NHS dentistry.

The £200 million plan was intended to deliver more than 1.5 million additional NHS dentistry treatments (or 2.5 million appointments) in 2024-25. It had
three components:

- Expanding access in 2024 so that 'everyone who needs to see a dentist will be able to', beginning with incentives to dental practices to deliver NHS care and introducing mobile dental vans for under-served communities
- Launching Smile for Life, a focus on prevention and good oral health in young children alongside a consultation on water fluoridation in north-east England
- Supporting and developing the dental workforce through measures in the NHS long-term workforce plan and setting the trajectory for further contract reforms.

2.3 Purpose of Visits

The main purpose of the visits was to look at resident's access to dental services and how care homes support residents with oral health.

The objectives of the project:

- Speak to as many residents as possible about their experience of accessing dental services and how well they are supported with oral hygiene routines.

- Allow Staff the opportunity to share their views and experiences of access to dental services for residents, and how well Staff are supported from management to implement good oral health promotion.

- Speak to management to gain an understanding of how accessible dental services are for residents, and how they support Staff to implement good oral health.

- Compare the 2019 reports to the 2024 reports and observe for any improvements, developments or reductions in the standards of oral health, promotion and access to dental services for residents. In care homes in North Lincolnshire.

2.3 Methodology

This report provides an overview of the themes and highlights good practice in relation to promotion and support with maintaining and improving dental health in care homes.

The managers at each care home were notified by email letter that a visit would be taking place. One weeks' notice was given with the date of the visit.

The aim across the care homes was to speak to managers, residents, family members and Staff. The visits took place at different times of day for around two hours in duration and the same questionnaires were used by all representatives in all care homes.

The care homes we visited were the homes that we had visited in 2019 except for Emerald House which has since closed, this was replaced with The Mount which is also a care home for adults with learning disabilities. The homes were originally selected as a mixture of residential over 65, and learning and physical disabilities for ages 18-65. We looked at homes rated by the CQC as 'Requires Improvement', Good', and 'Outstanding' across all care networks in Northern Lincolnshire.

Most of the settings we visited provided care for residents with learning disabilities or varying levels of dementia. Enter and view representatives ensured that this was taken into consideration when communicating with residents.

The size of the care homes varied, with capacity ranging from 6 –45 beds.

In total, the enter and view representatives listened to the views of 38 residents, 5 relatives / visitors, 40 members of Staff and 11 care home managers or deputy managers.

At the end of each visit, the enter and view lead representative provided feedback to each care home manager which allowed them to provide additional information if needed.

Following the visits, an individual report with recommendations was produced for each setting and shared with the providers who were given 20 days in which to respond.

All individual reports have been shared with the CQC, the Provider Development Team at North Lincolnshire Council and the Integrated Care Board and are available to read on the Healthwatch North Lincolnshire website.

Healthwatch intend to use the results of this report to contribute to ongoing work streams that are looking at the issue of access to dental services in North Lincolnshire. Prior to beginning the project discussions were held with the Northern Lincolnshire Public Health and the HNY Integrated Care Board to inform them of the upcoming project.

The following care homes were visited as part of the enter and view programme.

- Amber House
- Applegate
- Ascot House
- The Mount
- Holly House
- Lincolnshire House
- Lowfield House
- Norwood House
- Sycamore Lodge
- The Manor House
- The Willows

2.4 Acknowledgements

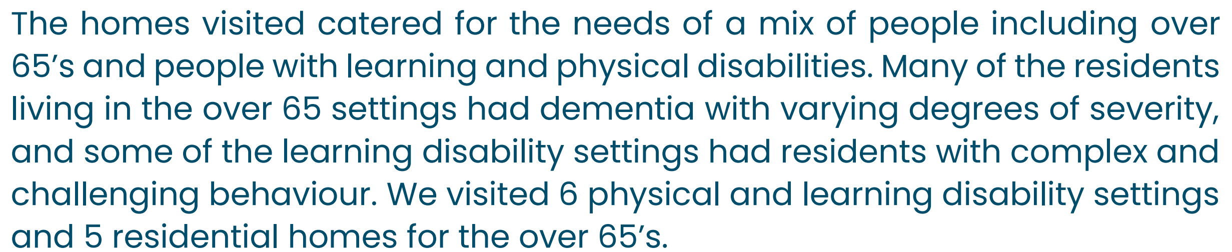
Healthwatch North Lincolnshire would like to thank the residents who shared their views during the enter and view visits and the Staff and Managers who welcomed our team into their care homes.

Healthwatch North Lincolnshire would also like to thank the team of dedicated volunteers for their valued contribution to the enter and view programme.

3 Findings

3.1 What did Residents say about oral health?

The enter and view team listened to 38 residents during the visits. The residents were aged 24-98, most residents we spoke to were male.



The homes visited catered for the needs of a mix of people including over 65's and people with learning and physical disabilities. Many of the residents living in the over 65 settings had dementia with varying degrees of severity, and some of the learning disability settings had residents with complex and challenging behaviour. We visited 6 physical and learning disability settings and 5 residential homes for the over 65's.

Oral health problems

Of the 38 residents we spoke to, 10 said that they had experienced problems with their mouth in the past 12 months.

In the over 65 settings, the most common problem was loose dentures, with 4 people saying that they had experienced this. Residents told us.

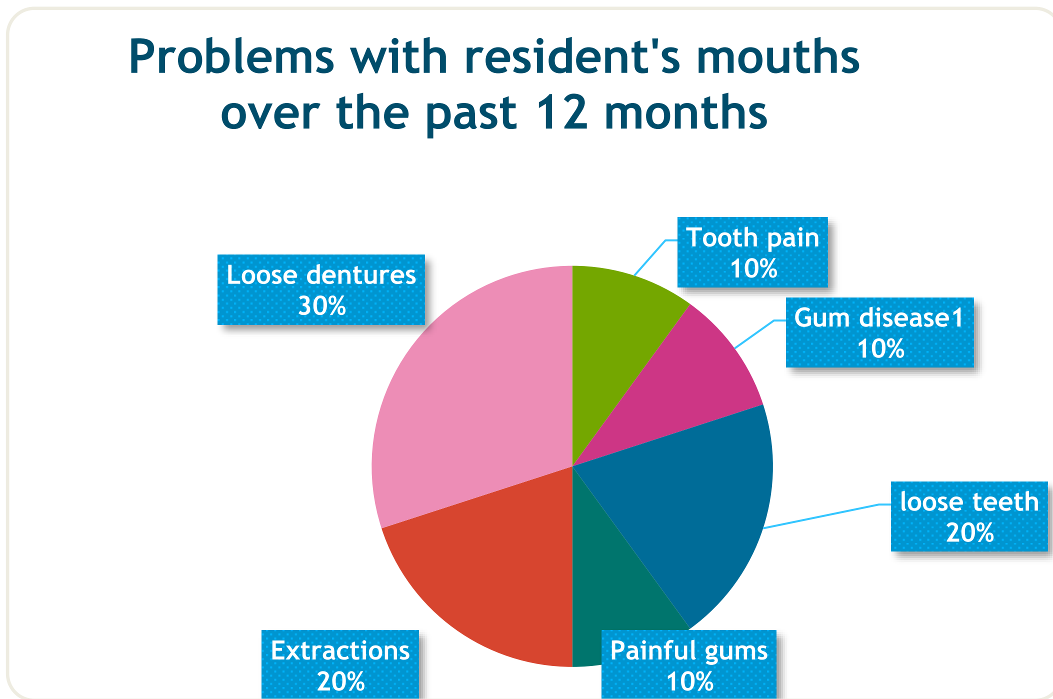
"I've had sore gums", they had been putting a bonjela on their gum before inserting their dentures.

"I don't have many problems, but I have had to start using Fixodent as my denture seems a little loose and I sometimes get food particles stuck underneath, which is uncomfortable"

"I've had no problems with my mouth although the bottom set of my dentures are a little loose, it is comfortable, though"

One resident advised they should wear a denture, but they don't due to it not fitting well and being uncomfortable. They prefer to eat soft food, because of this.

It is unclear whether all the residents raised their concerns with the care home at the time.



In the physical and learning disabilities homes, the most common problems were

"Gum disease"

"Ive had had two teeth out"

One resident had lost a tooth, it had fallen out and another informed Healthwatch that they had two wobbly teeth at the time of the visit.

One home has unfortunately had difficulties in accessing emergency treatment particularly for one resident who has been waiting for nearly a year for emergency surgery. They had been advised this was due to lack of theatre space.

Loose teeth can make chewing solid food more difficult and can cause pain and discomfort. If the lost teeth are not replaced, this can also cause problems with chewing and enjoying food, and nutrition may be compromised.

Dentures

Of the 38 people spoken to, 14 said they wear a full or partial denture, with only 4 saying that the denture fitted well.

All those residents who wear a denture live in residential care for over 65s.

Six had partial dentures as well as some of their own teeth.

Seven had a full set of dentures one resident advised they had had all their teeth removed at nineteen as they were crooked.

One resident advised they should wear a denture, but they don't due to it not fitting well and being uncomfortable. They advised us they prefer to eat soft food, because of this.

One advised they had a denture for the top, but it was upstairs in their bedroom, and they didn't wear it because it didn't fit very well.

Another resident advised they had no problems with their mouth although the bottom set of dentures was a little loose. They advised It is comfortable, though and they were happy with how it looks

One resident advised their denture fits well and is comfortable, they were happy with their appearance and had never lost their dentures.

One had problems with their mouth in the last year, with toothache.

Another had sore gums, they had been putting a bit of bonjela on their gum before inserting their dentures.

"I have had to start using Fixodent as my denture seems a little loose and I sometimes get food particles stuck underneath, which is uncomfortable".

Only two of the residents in the homes we visited had dentures with their names or initials engraved on them.

One of the care home managers has spoken to 543 Dental Service and spoken with the practice manager. She had asked whether this is a part of the package for the initials of the patients to be engraved on the dentures; after checking policies and general law around this is not any form of requirement and it is not provided in their package. As a care home, Sycamore Lodge expressed they would not be happy to interfere with the dentures of the residents, although it sounds helpful to have initials of residents on them the task cannot be completed with the marker pen as steradent would remove it immediately, the dentures would need to be engraved.

One resident informed us that they had never lost their dentures, but they had been taken, another told us they had lost them but soon got them back after they found them under the bed.

Apart from nuts and apples, no residents thought that their dentures caused them any issues or stopped them eating a particular food although some preferred a softer diet.

Attitudes to oral health

In comparison to the 2019 report the reoccurring theme amongst the over 65's was that many no longer thought that their oral health was important due to their age or a lack of natural teeth, with many assuming that they no longer need to see a dentist for regular check-ups.

One resident advised they don't have a regular dentist because they are frightened of going to the dentist and that they didn't need any help or support with oral care.

Two residents in one home stated that they didn't have a regular dentist anymore. One was unsure why and the other said that they didn't need to go anymore. Another care home resident stated they didn't see a dentist because they didn't need to see them anymore.

One resident stated, *"I'm quite happy, I have my dentures re-fitted every three or four years, you shouldn't be frightened to go to the dentist".*

A family member said that if they notice that their relative has halitosis, they ask the care staff to make sure their teeth and mouth are clean.

One resident advised *"I do it myself, but I haven't cleaned them lately, I should put them in a box with steradent tablets*".

One resident informed us that they had an electric toothbrush they like to use.

One resident had obvious decayed teeth but advised he didn't like going to see the dentist and that his teeth weren't causing them any pain.

Access to dental services

19 residents told us that they visit a dentist for regular check-ups, and 13 of the residents we spoke to received domiciliary visits.

According to Northern Lincolnshire and Goole NHS Foundation Trust (NLaG), the Community Dental Service exists to *offer oral health care for people who would struggle to access treatment from general dental services. This includes children with high levels of dental problems, and people with special needs such as physical disabilities, learning difficulties or mental health problems. Wheelchair users and bariatric patients can also be accommodated, and we have the facilities to offer conscious sedation and general anaesthetic.*

Staff can, where necessary, undertake home visits for those who are unable to attend a hospital or community dental appointment.

As well as providing a service for patients who have difficulty accessing treatment elsewhere, we also have a responsibility to monitor and improve the dental health of the local population.

Community dental - Northern Lincolnshire and Goole NHS Foundation Trust

There are two clinics based in Scunthorpe and residents can be referred into this service by care home managers, GP's, care workers, and other dentists.

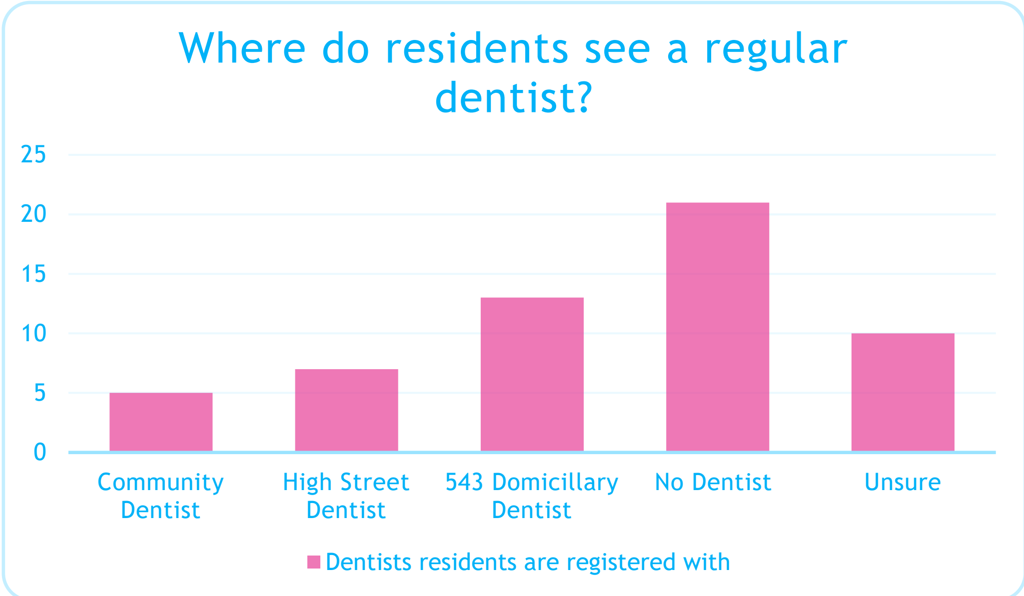
One resident advised he used the community dentist at The Ironstone Centre. He was very happy with the treatment he received.

543 Domiciliary dental service is based in Hull and visits care homes and housebound people. Anyone can refer via the self-referral form on the website. 543 dental centres are the only provider of domiciliary dental care in the area. Care home residents can receive regular check-ups and treatment in the home if they wish.

[543 Dental & Implant Centre | Private and NHS dentistry in Hull]

We received positive feedback about both service during our visits from residents and staff.

Several residents still have their own dentist and two stated that they go with a Carer in a taxi to a dentist in Ashby. Other dentists used were Barton Dental Service, Fieldside Dental Practice and Victoria Road Dentist in Ashby.



21residents told us that they do not have a regular dentist, stating they didn't know why or that this was due to either fear of the dentist and feeling that they no longer need to have check-ups due to age or lack of natural teeth.

Again, evidence shows residents in homes for over 65's were less likely to visit a dentist.

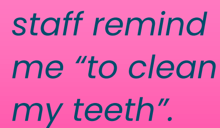
"My regular dentist is Mr. Stansfield, the community dentist at The Ironstone Centre. I'm very happy with the treatment I receive"

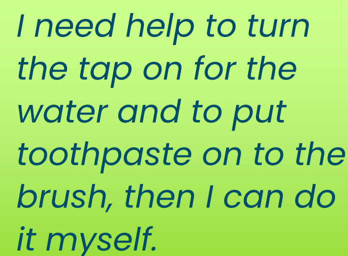
"I'm quite happy, I have my dentures re-fitted every three or four years, you shouldn't be frightened to go to the dentist".

Supporting oral health

Many residents we spoke to said that they were independent and didn't need support with brushing their teeth. Staff advised residents with dementia, physical and learning disabilities require more support, the homes we visited prompted independence as much as possible.

Most of the residents in physical and learning disability homes were prompted, supported or encouraged to brush their teeth by care Staff. One home was working with a resident to build independence skills around flossing his teeth. Overall residents were supported well with their oral health. As stated in the previous report some homes had promotional materials in communal bathrooms, and individual bedrooms promoting good oral hygiene. These included posters with images and diagrams demonstrated how to brush teeth, to promote the importance of a good oral hygiene routine.





3.2 What did Staff say?

The enter and view team spoke to 40 care staff during the visits to the 11 care homes.

Oral Health Policy

Of the 40 staff we spoke to 30 were aware of the homes oral health policy, one wasn't as she was the cook and 3 thought there would be a policy but that they weren't aware of it.

Statements from staff included

"It is available in the medications room" A copy of which was printed off and given to Healthwatch.

"They will have one but I'm not aware of it" another suggested she was aware and that is printed and in a folder in the cupboard.

One member of staff stated they were sure that the home had an oral health policy but were not sure if they had seen it. However, they stated that they had care plans and risk assessments for oral health.

Again, as highlighted in the 2019 report all the staff that were unsure if they had seen the oral health policy were working in the larger over 65's settings.

Oral health assessment

When asked if staff used templates and tools to assess oral health, such as the NICE oral health assessment tool, (see appendix a) all the homes we visited used an assessment tool. 6 homes used the NICE oral Health assessment tool and 5 used other templates and systems such as ASCOM, PCS and Reflect.

Feedback from staff was as follows.

"The oral needs of a resident are assessed on admission and there is a daily assessment documented on Ascom, the computer-based care plan system"

"I feel very confident with assessing residents' oral health needs and I'm confident in recognising signs and symptoms of dental pain and disease"

"The assessment tool used is the NICE recommended tool".

"Oral health needs of a resident are assessed upon admission, if there is a problem and every day during whilst supporting with oral care"

One member of staff stated" I would like to see a professional e.g. a dental hygienist come to the home to see residents and advise staff".

Training

Of 40 staff asked, 32 (80%) said that they had received oral health training and told us they received training online, shadowing, or as part of their care certificate. Specific oral health training was available to care staff in all the homes but two. These homes provided training as part of personal care training or induction. Staff advised that they preferred face to face training and that this would be beneficial for them. Several staff said they would like to access training, if they were given the opportunity.

In comparison to the 2019 report this was a significant improvement as previously reported **71%** of staff had **not** received any specific oral health training.

One home advised that they took it in turns for staff to observe the dental visits from the domiciliary service so help staff better understand residents' oral health requirements.

When we asked staff whether they felt they were able to spot the signs and symptoms of oral pain or disease in residents, 37 care staff said that they felt comfortable in spotting the signs and symptoms of oral pain. The staff who were unsure advised they would inform a senior member of staff and ask them to check.

Supporting Residents

31 staff members said that they felt they had sufficient time to care for resident's oral health and to support them with such things as teeth brushing. The remainder advised everyday was different and it depended on staffing and residents co-operation.

The learning disability homes residents were often supported on one-to-one hours which allowed plenty of time for oral care routines to take place.

We asked staff if they faced any challenges when trying to support residents with their oral hygiene routines. Some staff who cared for residents with dementia said that it can be challenging due to residents not understanding what is being asked of them.

Staff faced challenges such as helping their residents with dementia to understand why they needed to clean their teeth, the importance of oral hygiene, and to not swallow toothpaste. They used spare toothbrushes and toothpaste to demonstrate brushing as an aid to help residents maintain good oral hygiene.

Staff who worked with residents with physical and learning disabilities advised that they could face challenges when trying to promote and provide good oral health. Some residents are a reluctance to have teeth brushed or mouths that can't open very wide.

Staff advised they offer reassurance and encourage residents to brush their teeth. Distraction methods are used such as tickling to support residents with complex needs to ensure their oral health needs are met.

Staff commented that "*resident co-operation is not always good. We tend to repeatedly advise residents what to do and prompt them as to the next step when they are undertaking their oral hygiene. Patients with dementia often require calming and persuasive strategies*".

"Some residents don't like you to clean their teeth so you have to persevere, some will refuse and scream shaking their head from side to side it can be a real challenge"

Residents are supported dependent on their needs we use toothbrush and paste, mouth sponges, mouth spray and foam toothpaste it all depends on the person.

Dentures

Residents who had dentures were mostly supported with removal, cleaning and putting them back in, or soaking overnight. We asked staff how many times residents' dentures are cleaned 7 homes said very regularly and one said daily. For the remaining homes this question was not applicable as the residents did not wear dentures.

Only two of the residents we spoke too had their dentures marked for identification purposes. In one of the older adults homes the manager has spoken to 543 Dental Service practice manager. She had asked whether this is a part of the package for the initials of the patients to be engraved on the dentures; after checking policies and general law around this is not any form of requirement and it is not provided in their package. The home expressed they would not be happy to interfere with the dentures of the residents, although it sounds helpful to have initials of residents on them the task cannot be completed with the marker pen as streradent would remove it immediately, the dentures would need to be engraved.

"Teeth/ dentures are usually cleaned once a day, in the morning, sometimes at night too, and sometimes after meals, depending on what the residents have had to eat"

"Residents are supported to remove dentures if needed. One staff member stated "I have dentures myself, so I know what it's like "

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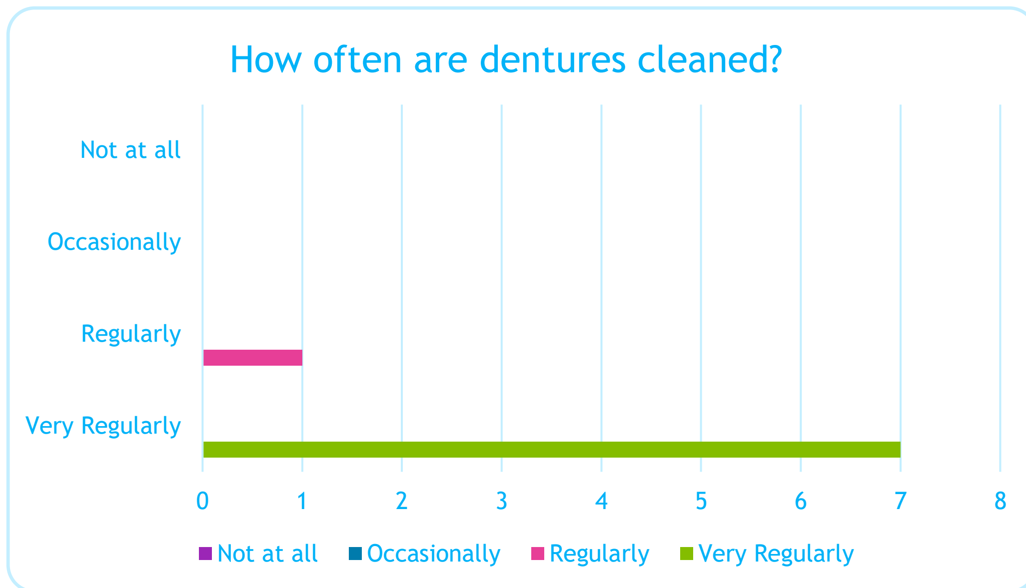


3.3. The Managers Questionnaire

In 2019 the CQC published that 39% out of 100 care homes spoken to were not aware of the NICE oral health guidelines despite considerable engagement with the social care sector since its launch in July 2016.[5]

In 2019 the homes visited in North Lincolnshire 5 out of 11 Managers we spoke to said that they had read and understood the guidelines, whereas 2 said that they were aware of them but have not read them. The remaining 36% (4) said that they were not aware of the guidelines and what they involved.

We wanted to speak to managers to understand whether they had implemented these guidelines since our last visit and gather further information regarding resident's oral health and access to dental services across Northern Lincolnshire.

NICE Oral Health Guidelines in Care Homes 2024

When we asked the Managers in 2024 if they were aware of the NICE oral health in guidelines in care homes, Of the 11 Managers spoken to, 4 said that they felt they had fully implemented these guidelines into their homes. 5 felt the guidelines were mostly implemented and, 2 partially implemented. This is an improvement on the 2019 report where all managers spoken too stated that they did not feel that the guidelines were fully implemented in their care homes.

[5] 7. CQC Smiling Matters
https://www.cqc.org.uk/sites/default/files/20190624_smiling_matters_full_report.pdf

Once again home managers advised that it can be difficult to always implement the guidelines due to challenging behaviour and lack of cooperation from residents. They explained due to dementia patients' behaviours it was difficult to transport them to a dentist and domiciliary and community dentists appeared reluctant to visit the more complex dementia homes.

Oral health policies

NICE recommends that care homes should have an oral health policy that 'sets out to promote and protect oral health' and records information such as.

- local general dental services and emergency or out-of-hours dental treatment
- community dental services, including special care Dentistry teams
- oral health promotion or similar services, depending on local arrangements
- assessment of residents' oral health and referral to dental practitioners
- plans for caring for residents' oral health
- daily mouth care and use of mouth and denture care products
- what happens if a resident refuses oral health care (in line with the Mental Capacity Act and local policies about refusal of care)
- supply of oral hygiene equipment (for example, basic toothbrush or toothpaste).[6]

Of the 11 Managers we spoke to, all 11 said that they had implemented a full policy that sets out to promote and protect the oral health of its residents. In the last report it stated that only four managers said that they had policies in place to cover aspects of oral health such as a personal care policy, but not one centralised policy that was specific to oral health.

This is big step forward in terms of protecting the oral health of residents living in Care homes.

[6] NICE NG48 - Oral Health in Care Homes. 2016

Oral health assessment

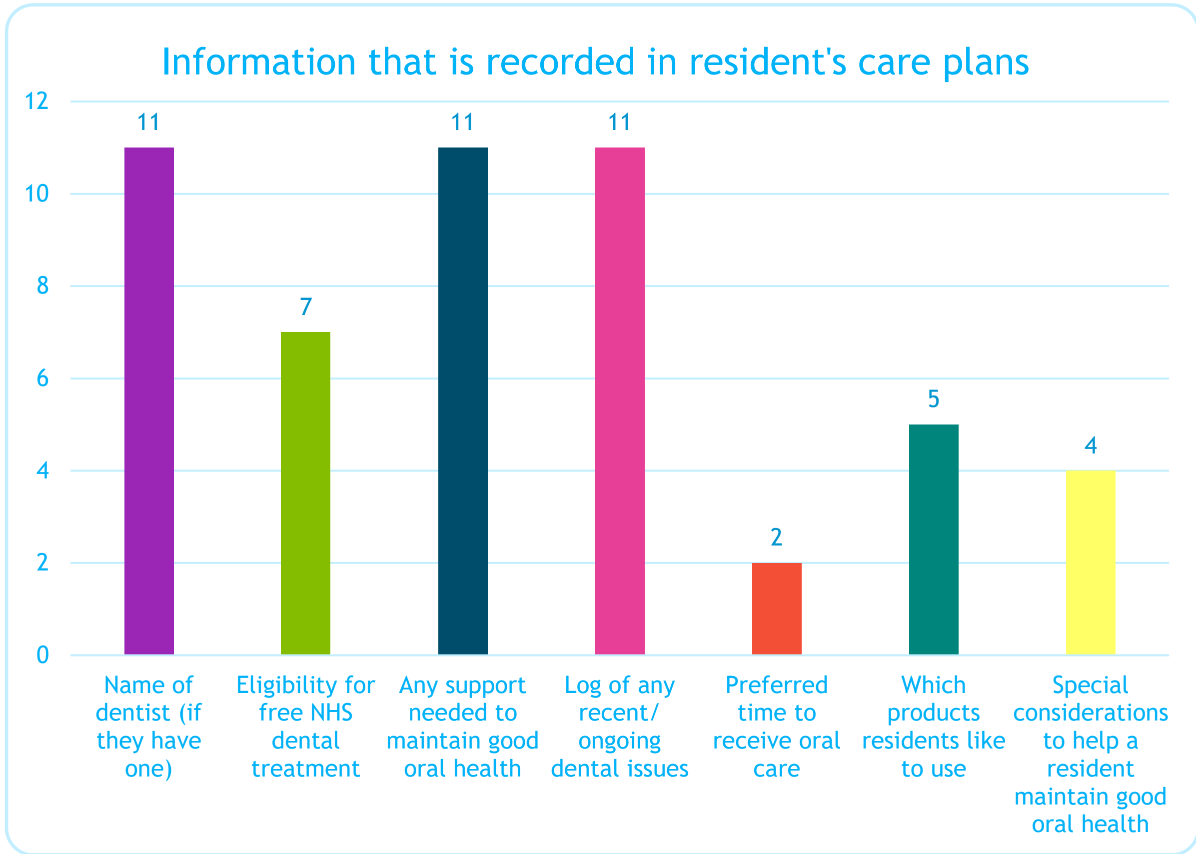
NICE recommends that '*Care Staff carrying out admission should assess the mouth care needs of its residents as soon as they start living in the care home'*

We asked Manager's if resident's oral health was assessed on admission into the home. 9 Managers told us that this is always carried out, whereas 2 Manager's said that this was not undertaken. Of the 11 homes 6 homes used the NICE infographic to assess oral health. The other homes had various alternative assessment tools and risk assessments including Sharepoint, PCS (Person Centred Software), ASCOM and REFLECT.

We asked Managers if residents' care plans recorded the name and address of their registered Dentist. All homes said that this information was included in care plans, if the resident had a dentist.

All 11 Manager's said that a log of any recent and or ongoing dental problems is recorded in care plans. Once again Healthwatch found that care plans in learning and physical disability settings were more in depth and included more information, such as supporting a resident and any special considerations. Learning disability homes where more likely to have prescribed toothpastes and mouthwash.

We asked Managers if care plans contained information on the residents' eligibility for free NHS dental care. 7 homes recorded information about residents being exempt from NHS dental charges, 5 were learning or physical disability homes. The CQC found that many people believed NHS dental care was free to anyone residing in a care home, and that staff awareness and knowledge of NHS dental exemption charges was poor. The CQC found that lack of understanding may be exacerbated by problems in recording whether residents were entitled to free NHS dental treatment and care. This knowledge has improved in the homes that we visited, and 7 homes had clear understanding of the exemption charges.

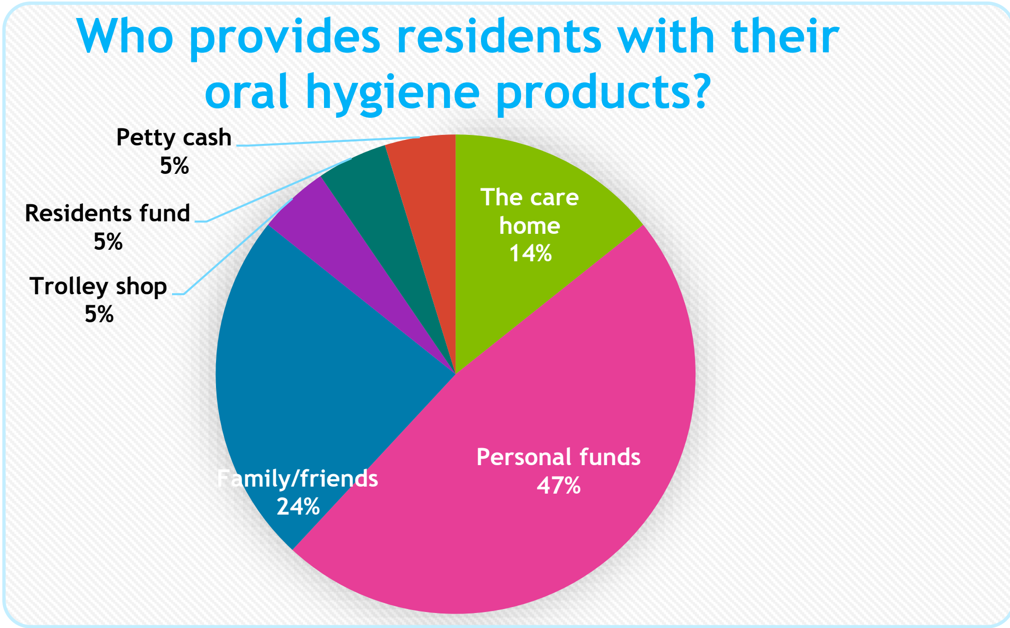


Provision of oral health products

When Managers were asked about the provision of oral health products for residents, there was a difference in the type of setting. Residential homes for physical and learning disabilities all said that most residents purchased their own toothpaste, toothbrushes etc. with their personal funds during shopping trips with keyworkers to promote independence.

Over 65 homes had provisions such as the trolley shop that went around every other day and provided items such as toiletries, toothpaste and toothbrushes. Other homes would purchase residents' items out of petty cash or residents' funds if they required items in an emergency.

Family and friends regularly brought in items as needed for their loved ones.



Staff training

During the 2024 visits only two of the homes we spoke to said that training specific in oral health wasn't provided. However, in these homes training was provided on oral health as part of personal hygiene training, the Care Certificate or during staff induction.

Staff received this training via various e-learning platforms including CURVE and Florence. All homes reviewed the training or completed refreshers on either a yearly or three yearly basis.

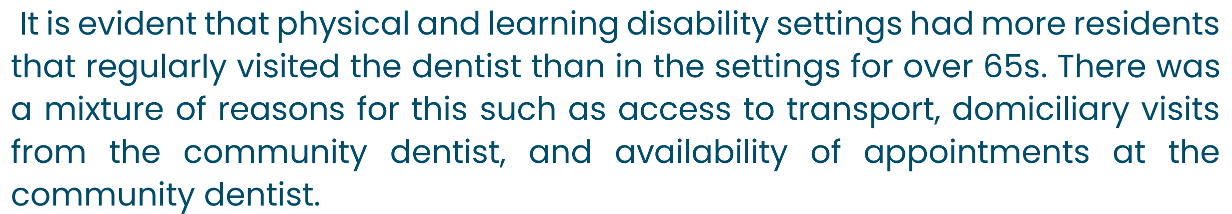
Staff also shadowed sessions when the domiciliary dentist visited the home for further knowledge on how best to support the residents.

This is huge progress across most of the homes as in the 2019 report it is recorded that only one home was providing oral health training to their staff.

Access to routine dental treatment

We asked Managers how many of their residents regularly visit the dentist for routine check-ups and treatment. Nine homes said that their residents were registered with a dentist. Six homes were registered with the community dentist at The Ironstone/Ashby Clinic. Three homes were registered with 543 Domiciliary Dental Services and seven homes said several of their residents are registered with private dentists in Barton, Brigg and Hull.

The two homes that advised their residents weren't registered with a dentist relied on the G.P visiting weekly to support with any oral health issues or using emergency dentists if there was a concern. The homes were all over 65 homes providing dementia care.



It is evident that physical and learning disability settings had more residents that regularly visited the dentist than in the settings for over 65s. There was a mixture of reasons for this such as access to transport, domiciliary visits from the community dentist, and availability of appointments at the community dentist.

One manager highlighted that in the over 65 care homes many residents don't have access to a dentist; this is because it can be difficult for some residents to visit a dentist and allow treatment due to confusion and behaviour. It can also be difficult for residents to visit a dentist outside of the home. One manager advised dentists are reluctant to visit a dementia home and do not appear to have dementia awareness training.

Another advised residents don't have regular check-ups, however a G.P visits weekly and if there are any concerns they would refer to a dentist. The SPA team are also good if required.

Most of the homes that had referred to and used the Community Dental Service and had found the experience positive.

However, one home advised the community dental service used to visit the home annually to undertake routine check-ups. However recently the dentist has not visited, and the home have had difficulties getting appointments. All residents can leave the home and attend an appointment if needed however the manager informed Healthwatch that no one answers the phone or responds to emails at the community dentist which is causing concern and frustration.

Another advised the domiciliary dentist visits the setting frequently, and the Manager feels that she has a good relationship with the Community Dental service. She finds the referral process simple, and the service very responsive. However, the current waiting time for one resident's surgical treatment is "ridiculous" (they have been waiting nearly a year)

The three homes that are registered with 543 Dental service advised the service was excellent and that residents received regular check ups and treatment as required. However, they have recently been advised that there are several staff shortages and waiting times are much longer than they were previously. Following conversation with the ICB Dental lead they are aware of these concerns and are currently looking at reviewing this service.

Access to treatment in an emergency

Managers were asked what the procedure was if a resident was suffering with severe pain /swelling and needed urgent treatment out of hours.

The managers gave a mixed response to this question with some saying they would call the single point of access (SPA) team or NHS 111 and choose option 1 for dental problems and advice. Two homes advised if they would take the resident to A+E if required.

Several homes advised they have a G.P/Nurse practitioner visit on a weekly basis and if they had any concerns they would speak to the visiting G.P and they could advise, refer or treat the concern.

One manager told us that they have a protocol in place to treat a resident that did not access any dental care. This is a decision made by the resident who refuses to engage in oral health interventions. This is thought to be due to previous trauma. The Manager has worked with the Community Dentist to develop a plan for this resident to ensure that the most appropriate treatment would be provided if a dental emergency was to occur.

One resident has unfortunately been waiting for treatment under local anaesthetic for nearly a year. This was a decision made under best interests. The Manager has been informed this wait is due to a lack of theatre space.

If a resident required emergency treatment the home would ring and attempt and get a same day appointment. In the past year there have been two incidents of residents requiring emergency treatment. There has not been an issue with getting appointments if there was the home would ring 111.

One manager advised the community dentist was brilliant and had come out into the car park to treat a patient in pain and discomfort as they were frightened to attend the surgery.

None of the homes felt they would struggle to gain emergency treatment for their residents.

3.4 Differences between types of providers.

Comparisons were made between the type of settings we visited, regarding support, access to dental services, and the promotion of good oral health.

The information we received highlights similar themes as recorded in the 2019 report.

Learning and physical disabilities

- Most residents were registered with a dentist and received regular check-ups and treatment.
- Most of the residents were prompted and supported with their oral hygiene by Staff.
- Most residents had some one-to-one hours and staff had adequate time to support with oral health tasks.

Residential care (over 65s)

- Smaller numbers of residents were registered with a Dentist.
- Fewer accessed a Dentist for check-ups and treatment and felt due to age that they didn't need to see a Dentist.

Dementia care

- Few residents were registered with a Dentist.
- The majority of residents have not received dental treatment recently.
- Staff said that it was more challenging supporting residents with their oral health due to communication, transport and behaviour problems.

3.5 The Care Home Environment

The enter and view teams spent time during their visits observing the care home environment, paying particular attention to the promotion of good oral health.

All the care homes were proactive in promoting good oral health and hygiene; however not all residents were registered with a dentist. Several homes had pictorial posters in communal bathrooms or individual bedrooms which prompted and encouraged residents to brush their teeth and informed them of how to do this.

All of the settings had basic oral hygiene products such as toothbrushes, denture brushes and toothpaste available in resident's bedrooms or communal bathrooms. Funds were available to purchase and replace items as needed.

In a few of the care homes we saw that some residents had prescription mouthwash; prescription toothpaste which is higher in fluoride, Floss and foam toothpaste. Many of the residents used electric toothbrushes.

4. Conclusion

When comparing the recent findings to the enter and view visits to the results of the "Getting to the root of the problem" project in 2019, it is evident that there has been improvement in the support residents receive with their oral health care in North Lincolnshire.

The NICE guidelines NG48 – 'Oral Health in Care homes' have been mostly implemented by care home managers, since the completion of the 2019 project.

All care homes we visited had an oral health policy in place.

All care homes visited were now using an oral health assessment tool. 6 homes were using the NICE NG58 guidelines assessment tool and 5 were using tools such as ASCOM, Sharepoint, PCS and Reflect.

The findings replicated the 2019 report and once again highlighted oral health and access to dental services in care homes varied from setting to setting. In the settings for people with learning disabilities or physical disabilities, the resident's oral health seemed to be better than those living in over 65 settings. This was due to fact that more residents from this cohort had access to a regular dentist and had more support with daily oral health routines. This could also be because generally, people living in these settings were younger, and the impact of age on oral health was yet to be seen.

Residents living in homes for the over 65's reported more issues with oral health and had poorer access to dental services.

Many residents in homes for over 65's often didn't feel the need to see a dentist due to their age or lack of natural teeth. This could be changed through positive encouragement, promotion of oral health, and support with oral hygiene from Staff and family members.

Training in oral health has improved in most settings visited. Most staff said they felt confident recognising the signs of symptoms of poor dental health and how to support with daily oral hygiene routines, they felt this could be further improved with the addition of specific face to face oral health training.

Staff have a good understanding of individual resident's needs, and despite the challenges some faced when supporting residents, they are flexible in finding ways to help, . Patients with dementia often require calming and persuasive strategies".

Most staff who took part in the visits showed a positive attitude to promoting good oral health and it was clear that they saw this as an important part of a resident's health and wellbeing.

5. Recommendations

1. Managers should complete a review of all residents and whether they have routine dental check-ups with a dentist. Attempts should be made to secure an NHS dentist for those who do not have one, this could be via private, community or domiciliary dental service.
2. All staff within care homes should undertake specific oral health training. Training should be offered on induction and refreshed at regular intervals. On moving to a new care home, Staff should be assessed, trained and updated where necessary. The following free training course can be accessed online -

- ✓ https://www.e-lfh.org.uk/bite-sized-mouth-care-guidance-now-available-for-all-healthcare-staff/

3. Care staff should revisit Care homes oral health policies on a regular basis to refresh their knowledge and refresh the policy expectations.
4. Care staff should be shown how to care for resident's dentures and be informed of the importance of removing and cleaning dentures daily.
5. Residents should be provided with oral health advice, including how to look after their dentures, and should be encouraged to see a

dentist for regular check-ups, regardless of whether they have teeth.

6. ICB Dental Commissioners should ensure that any upcoming changes to commissioning reflect the needs of those specifically living in care homes.
7. ICB commissioners should consider reviewing the domiciliary and community dental service to ensure that it is accessible to all that require the service.
8. ICB Dental Commissioners should work with the local authority to ensure that all care homes are aware of how to access dental services. This should include the domiciliary service, the Community Dental Service, and the 111 pathways for emergency dental treatment.
9. The Local Authority should ensure that the recommendations within this report are incorporated into current mechanisms for improving quality within the care home sector.

Healthwatch aim to continue to support the promotion of oral health in care homes by taking the following actions.

- Promote the importance of good oral health and provide up to date information in the Healthwatch newsletter, website and other platforms.
- Continued involvement in current work streams that are focussing on the issue of dental health.

6 Next steps

Under Healthwatch powers to produce reports and recommendations, the following services were given 20 working days from receipt to respond:

- Amber House
- Applegate
- Ascot House
- The Mount
- Holly House
- Lincolnshire House

- Lowfield House
- Norwood House
- Sycamore Lodge
- The Manor House
- The Willows

Healthwatch North Lincolnshire will monitor responses to the recommendations within this report and keep members of the public and stakeholders informed of progress and actions to deliver improved services.

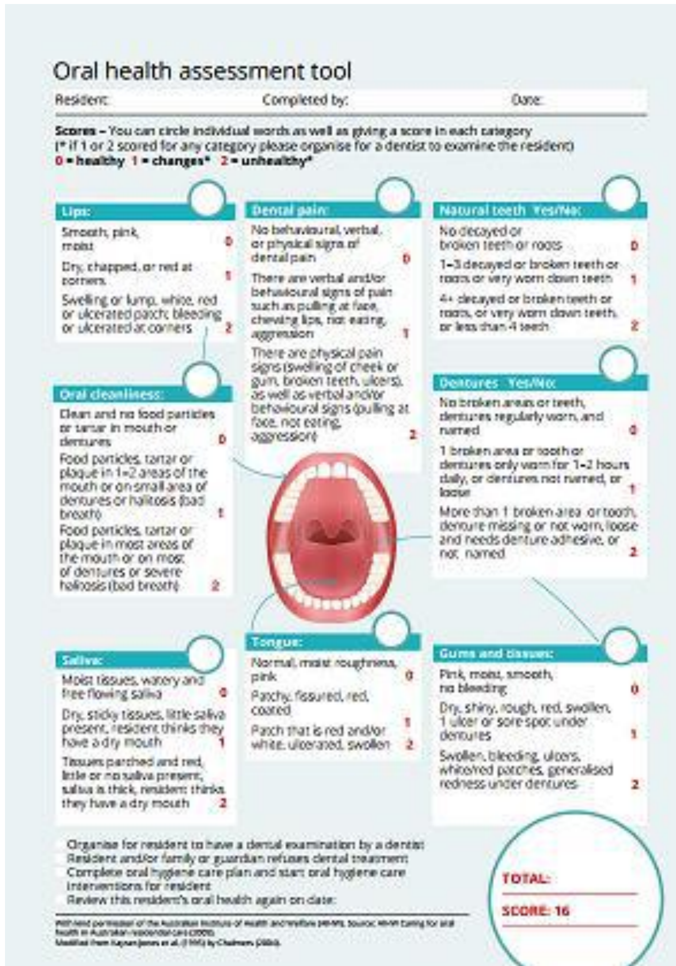
Healthwatch North Lincolnshire will also share this report with the following groups and organisations:

- All Care Homes in North Lincolnshire
- The Provider Development Team at North Lincolnshire Council
- North Lincolnshire Safeguarding Adults Team
- The Care Quality Commission
- The Health and Social Care Standards Board

The report will be published, along with responses on the Healthwatch North Lincolnshire website.

APPENDIX

Tool available at
https://www.nice.org.uk/Media/Default/Oral%20health%20toolkit/Oral_health_assessment_tool.pdf



Oral health assessment tool

Resident: Completed by: Date:

Scores – You can circle individual words as well as giving a score in each category
(* if 1 or 2 scored for any category please organise for a dentist to examine the resident)
0 = healthy 1 = changes* 2 = unhealthy*

Lips:
- Smooth, pink, moist 0
- Dry, chapped, or red at corners 1
- Swelling or lump, white, red or ulcerated patch; bleeding or ulcerated at corners 2

Dental pain:
- No behavioural, verbal, or physical signs of dental pain 0
- There are verbal and/or behavioural signs of pain such as pulling at face, chewing lips, not eating, aggression 1
- There are physical pain signs (swelling of cheek or gum, broken teeth, ulcers), as well as verbal and/or behavioural signs (pulling at face, not eating, aggression) 2

Natural teeth Yes/No:
- No decayed or broken teeth or roots 0
- 1–3 decayed or broken teeth or roots or very worn down teeth 1
- 4+ decayed or broken teeth or roots, or very worn down teeth, or less than 4 teeth 2

Oral cleanliness:
- Clean and no food particles or tartar in mouth or dentures 0
- Food particles, tartar or plaque in 1–2 areas of the mouth or on small area of dentures or halitosis (bad breath) 1
- Food particles, tartar or plaque in most areas of the mouth or on most of dentures or severe halitosis (bad breath) 2

Dentures Yes/No:
- No broken areas or teeth, dentures regularly worn, and named 0
- 1 broken area or tooth or dentures only worn for 1–2 hours daily, or dentures not named, or loose 1
- More than 1 broken area or tooth, denture missing or not worn, loose and needs denture adhesive, or not named 2

Saliva:
- Moist tissues, watery and free flowing saliva 0
- Dry, sticky tissues, little saliva present, resident thinks they have a dry mouth 1
- Tissues parched and red, little or no saliva present, saliva is thick, resident thinks they have a dry mouth 2

Tongue:
- Normal, moist roughness, pink 0
- Patchy, fissured, red, coated 1
- Patch that is red and/or white, ulcerated, swollen 2

Gums and tissues:
- Pink, moist, smooth, no bleeding 0
- Dry, shiny, rough, red, swollen, 1 ulcer or sore spot under dentures 1
- Swollen, bleeding, ulcers, white/red patches, generalised redness under dentures 2

- Organise for resident to have a dental examination by a dentist
- Resident and/or family or guardian refuses dental treatment
- Complete oral hygiene care plan and start oral hygiene care interventions for resident
- Review this resident's oral health again on date:

TOTAL:
SCORE: 16