Communication 1 about ‘Adults in Practices survey’

A survey of oral health and service use among adults attending general dental practice, 2017/18

Background

It has been widely recognised that there is limited local information about the oral health of adults and this hampers the ability to commission oral health improvement programmes and clinical treatment services.

Public Health England (PHE) will be facilitating a national survey which is designed to provide local level information on the oral health of this group and their use of dental services, which will help agencies improve oral health and reduce inequalities.

A national Adult Dental Health Survey has been carried out every 10 years since 1968, and this provides information at regional level on a wide range of relevant issues and detailed clinical measures. The survey being described here is not intended to replace the ADHS, but to be complementary to it. This survey will involve a far larger sample than the ADHS and so will allow reporting of narrower range of pertinent data at local authority level. This will provide greater utility at a local level to support LAs and the NHS in their statutory functions.

Aim

The aim will be to produce information that assists commissioners to know

-what the oral health needs of the adult population are

-whether these needs are being met

-how best to commission services to meet the needs of adult patients

The survey will also provide an opportunity to compare the DT MT FT figures recorded by general dental practitioners (GDPs) on FP17 forms with a similar measure recorded by epidemiology examiners. The scores by GDPs are generated following a full examination and assessment which may include, for example, radiographic information. The epidemiology examiners will conduct a simple examination without the benefit of radiographic evidence.
By facilitating the comparison, an important stage will be achieved to maximising the use of this measure from FP17s.

Method

The survey is in the early stages of planning and a multi-agency group has been formed to oversee this. Consideration of possible methods of encountering the adult population showed that sample bias was likely to occur with any approach. Since only 2% of the adult population never attend the dentist, the dental practice setting is potentially one of the best locations to carry out a survey in order to reach a wide range of adults efficiently. By running a national survey the overall sample will include rare attenders as well as those who attend only with symptoms and those who attend regularly.

The planning group includes those from local authorities, British Dental Association, Faculty of General Dental Practitioners, NHS England commissioners, Local Dental Networks, Office of the Chief Dental Officer, dental epidemiology fieldwork providers, regional Dental Epidemiology Coordinators and academics. They are fully aware of the need to design a survey which conforms to scientific demands, is feasible to deliver across multiple sites and will produce information that is useful to commissioners.

Partnership working is essential and clinicians should be assured that all the information produced will be anonymised at patient, performer and practice level and therefore cannot be used for performance management.

For those practices which are randomly selected and agree to participate, there will be potential for feedback to the practice in the form of an audit which will entitle those participating to be certified for CPD. In addition, other forms of recompense and recognition are currently being explored.

The content of the survey questionnaire will be dictated by the feedback provided by all LAs who are currently being asked for responses. The method will be piloted to ensure it is feasible and acceptable to patients, practices and epidemiology fieldwork teams.

Commissioned epidemiology fieldwork teams, who are generally provided by Community Dental Services (CDSs), will be trained in the survey method and specifically with regard to running a self-administered questionnaire and undertaking a simple clinical examination.

Within each local authority in England general dental practices (NHS, private and mixed) will be randomly sampled, contacted and asked to assist with the survey. Where possible, larger practices will be sampled and contacted first. The practices will be asked to host the epidemiology team for a day or two half days, at a convenient time when a surgery is free, and the team will approach adult patients in the waiting room to ask them to take part in the survey. Those who agree and sign consent forms will be asked to fill in a questionnaire (about 10 mins), share a few details from their FP17 (NHS patients only) and have a brief examination (about 10 mins). The team will ensure that none of these activities disturbs the normal running of the practice and will be fitted around appointments. Members of the epidemiology team will make it clear to patients that they are not able to comment or answer
questions about their oral health, treatment plans, treatment that has been provided or the
general care provided by members of the practice team.

Within each local authority there will be a requirement for a minimum of 160 adults to be
surveyed, drawn from a minimum of 10 general dental practices. This will roughly equate to
the same level of resource as for child caries surveys run in schools.

Usual data protection legislation will apply and the teams will use the same secure methods
to enter the anonymised data onto computer and send it to the PHE Epidemiology Team for
collation, analysis and reporting. No reports will refer to individual patients, performers or
practices. Only group level information will be reported.

The timeline for this survey is:

By end of May ’17 – completion of consultation of all LAs by PHE Centre-based Consultants
in Dental Public Health

May, June, July – development of method and piloting, production of final protocol

July, August – production of population sampling frame and sampling, by PHE Epidemiology
Team (PHE ET)

September, October – regional training for fieldwork teams

October ’17 – June ‘18– fieldwork in practices

July ’18 – data sent securely to DECs and uploaded to PHE ET site

August ’18 onwards – checking, cleaning, collation of data, analysis and reporting.

Q and A

Q  How will local authorities benefit from this survey?

• They will have information about the oral health needs of the adults in their population. 
  This will assist with their statutory roles of monitoring health, overseeing provision of
  treatment services and formulation of Joint Strategic Needs Assessments and oral
  health strategies.
• Inequalities in oral health will be described.
• The questionnaire could be made available as a stand-alone tool to collect
  comparative information from sub-groups of the adult population which are of
  particular interest to individual LAs.
Q How will patients benefit from this survey?

- Commissioners of health improvement services, and clinical services will know more about what patients need and be able to respond accordingly to meet these needs.
- They will identify inequalities in health and service use and be much more informed about how to tackle these.

Q How will general dental practices benefit from this survey?

- They will know more about the needs of the adult population they serve and how these compare with other areas.
- Commissioning of services should be more attuned to patient needs and so allow better service provision.

Q How will NHS England benefit from this survey?

NHS Commissioners, Local Dental Networks and Sustainability and Transformation Partnerships will benefit from this information in their planning and delivery of locally focussed, integrated oral health services for adults.

Q Could the information collected in the survey be used by commissioners to manage activity in dental practices?

No, this cannot happen as the data will be anonymised for practice, performer and patient. Also NHSE teams will not have access to the raw data. NHS England is supportive of the survey because it will give them a far better picture of the oral health needs of adult patients in their local areas.

Q Will information about individual patients or practices be revealed?

No, the data will be anonymised when it is entered into the secure data collection programme so it will not be possible to identify individual practices, performers or patients. The survey is only interested in reporting the health needs and service use of groups, not individuals. The data will be kept securely using methods that comply with the Data Protection Act (1998).

Q Why is the DT MT FT information from patients’ FP17 forms being requested?

GDPs are very good at providing this measure on claim forms but the information needs to be validated before it can be used to provide description and monitor the decay levels in the population. Anonymous comparison of the measure against an epidemiological examiner is an important part of the validation process. It is well understood that there are likely to be systematic and random discrepancies between the two types of recording but it is important to know what these are and if they are significant.
Q **Will practices be paid to take part?**

Discussions are under way to consider a fair and consistent way to recognise the important role practices have in hosting the epidemiology teams and allowing them to approach patients and recompense them. Each sampled practice will be asked to host their local fieldwork team (one interviewer/recorder and one trained epidemiology clinician) for a day or two half days or equivalent.

Q **Will the survey cause changes to be made to appointments?**

No, as practice clinical teams will not be asked to take any part in the data collection. The survey protocol and training will emphasise the need for fieldwork teams to arrange to visit practices at convenient times, when one surgery is not being used. They will be trained to be very flexible in their approach with volunteer patients and work around appointment times so that treatment sessions will not be affected.

Q **Who will decide what goes into the questionnaire?**

The PHE lead for epidemiology, with the LA representative on the planning group, will compile the questionnaire based on the responses from local authorities who are all being consulted by their partner Consultants in Dental Public Health.

Q **Can practices refuse to take part?**

Yes, of course, participation is not compulsory but BDA, NHS E, LDNs and the FGDP are all supportive of this initiative and very much hope practices will be willing to take part so that patients, practices, and local commissioning can all benefit.

Q **Who is responsible for safe-keeping of the information that is collected?**

The fieldwork teams who collect the data, the PHE Dental Epidemiology Coordinators and the PHE DPH National Epidemiology team are responsible at various stages and all work with knowledge of, and within, the Data Protection Act. Information Governance responsibility lies with the PHE Risk Factors Team within the Chief Knowledge Officer’s division, working with PHE DPH National Epidemiology Team.

Q **How does this survey differ from the Adult Dental Health Survey?**

The ADHS provides a very wide range of in-depth information about oral health among adults using a consistent methodology which has allowed robust information about trends in oral health since 1968. This series has facilitated workforce planning, tailoring of clinician training, contract reform and commissioning of services to meet the current oral health needs of the population. The demands of the detailed clinical examination and extensive questionnaire mean that only a relatively small sample can be included so information can only reported at regional level.

The proposed survey of adults encountered in practices will involve a far larger sample so that information at local authority level can be produced, albeit with a narrower range of issues in the questionnaire and only essential detail in the clinical examination. Statements about trends in oral health cannot be drawn from this new method of data collection.
Further communications will follow as greater clarity about the methods emerges.