Rapid Oral Health Needs Assessment Yorkshire & the Humber May 2022

Understanding oral health inequalities in Yorkshire and the Humber and the evidence base

South Yorkshire

Foreword

Please note it is the intention that this ICS focussed document is read in conjunction with the main document *Rapid Oral Health Needs Assessment, Yorkshire and the Humber, May 2022*. This supplemental document provides highlights from the main document for a specific ICS (South Yorkshire ICS), where data has been available at the level of local authority, which could then be aligned with a specific ICS geographical footprint. The main document provides greater detail, and additional sections, in relation to oral health needs, the evidence base, oral health inequalities and recommendations for Yorkshire and the Humber region, including the other Y&tH ICS footprints.

Rapid Oral Health Needs Assessment Yorkshire & the Humber 2022
South Yorkshire ICS
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Executive Summary

The purpose of this rapid oral health needs assessment is to help understand the oral health inequalities across Yorkshire and the Humber (Y&tH) and the evidence base in order to inform principles underpinning strategy and work programme development; address inequalities; and meet population need and demand. It also supports a multi-stakeholder approach to the commissioning of prevention programmes to improve oral health and reduce oral health inequalities.

Poor oral health is largely preventable and is essential for good general health throughout the life course, enabling individuals to eat, speak, and socialise without pain or embarrassment.

I. Limitations of the Rapid Oral Health Needs Assessment

It is important to acknowledge the limitations when considering the findings including:

- Availability, accessibility, robustness, and the timeframe to collate relevant datasets.
- The focus of this rapid oral health needs assessment has been on identifying oral health inequalities, with recommendations based on principle. There will be a need for further investigation of the data to develop an understanding of where prioritisation is needed, aligned with services and care pathways.
- Limitations of available evidence on oral health inequalities related to:
    - Protected characteristics with mixed or inconclusive evidence related to pregnancy/ maternity and religion, and limited data available for oral health inequalities related to ethnicity but evidence related to oral cancer, caries, and tooth loss.
    - Vulnerable groups – prisoners, Gypsy Roma, and Traveller communities, looked after children and bariatric patients.
- This rapid oral health needs assessment does not provide a comprehensive overview of the totality of commissioned dental services in Y&tH e.g. dental services commissioned by Health and Justice in secure settings, nor identify any gaps in service provision, but it does provide recommendations in relation to prioritisation of care pathway work to inform future commissioning and service model design.

II. Key findings from Yorkshire and the Humber

- Inequalities in oral health exist with those in the most deprived areas experiencing poorer oral health across all age groups.
- 3-year-olds in Y&tH have the greatest experience of tooth decay nationally (Y&H – 15%; England 12%).
- By the age of 5-years in Yorkshire and the Humber, 29% have experience of tooth decay, the second highest prevalence nationally (England 23%) (Range Ryedale – 11% to Sheffield – 41%).
- For those children with experience of tooth decay, by the time they reach 5 years of age they will on average have 4 teeth that are either decayed, extracted, or filled (Range: Craven 2 – Bradford 4.3 teeth).
- Tooth decay can cause problems with eating, sleeping, communication and socialising, and can result in missed days from school for hospital extractions and time off work for carers.

- Tooth decay is still the most common reason for hospital admissions in the 6-10-year-old age group and 2-3% of children in Local Authorities across South Yorkshire had teeth extracted under general anaesthetic in 2019, the highest levels seen nationally.
- There is evidence of oral health inequalities associated with disability in terms of caries, dental access, tooth loss, traumatic dental injuries, oral health behaviours and quality of life.
- Y&tH has an ageing population. Over the next two decades the population of older adults (65+ years) is expected to increase by 33% and for those aged 85+ years is expected to increase by 66%. 42% of mildly dependant older adults had a functional dentition (21 or more teeth) with an expectation of retaining their teeth for life.
- Incidence of oral cancer is significantly higher in Y&tH when compared with England.
- There are limited contractual levers from which to re-distribute resource to promote oral health prevention and support dentists in treating high needs patients.
- A health equity audit should be used to determine equity of access to dental services, including urgent care services, and evaluate the outcomes from initiatives to improve access across Y&tH, the findings of which should inform future commissioning decisions.

***Top priorities**:*

Particular consideration should be given to those that have both the greatest dental need and experience challenges in accessing routine and urgent dental care. This includes individuals and communities that are deprived, vulnerable children known to the social care system, individuals with severe physical and/or learning disabilities, those with poor mental health, older adults, homeless, asylum seekers, refugees and migrants. Data and evidence surrounding oral health inequalities is variable and complex, but we know that they also exist in relation to oral cancer as well as in vulnerable groups with long-standing medical conditions, substance misuse, prisoners/prison leavers and Gypsy, Roma, and Traveller communities.

As a priority, a Community Dental Service (CDS) service review should encompass the entire special care dentistry and paediatric pathway and consider benefits of a Referral Management System (RMS). A service review of prison dental services in Yorkshire and the Humber is being undertaken separately. Considering the complex needs of the older and ageing population, care pathways for housebound or those living in residential and nursing settings should be reviewed. The review of current dental services for people with no fixed abode in Y&tH can be used to inform robust care pathway design, commissioned models and support implementation.

Available Healthwatch reports were used to inform the rapid needs assessment. It is important that commissioned dental services including service design and development work consider the views, beliefs, and experiences of the public and patients living in Y&tH to improve patient safety, experience, and health outcomes. Building on work to date, NHSEI should continue to work in partnership with key stakeholders, including Healthwatch, to maximise opportunities to ensure patient centred services improve access, reduce inequalities in communities and make better use of resources.

Aim:

The aim is to support commissioning teams with prioritisation and targeting of oral health care provision to reduce inequalities to access to NHS dental care across Y&tH.

Objectives:

- Use readily available data sources to highlight predicted population demographics, prevalence of oral health disease and oral health inequalities and inequities across Yorkshire and the Humber.

- To utilise the initial findings to inform targeted work to explore how oral health inequalities and inequities can be addressed and inform future workstreams.

Integrated Care Systems (ICS)

Where possible local authority data has been aligned with the current geographical footprints of South Yorkshire Integrated Care System (ICS) which is outlined in table 1 below.

Table 1: ICS footprint aligned with Yorkshire & the Humber Local Authorities

ICS	Local Authority
South Yorkshire	Barnsley
	Doncaster
	Rotherham
	Sheffield

Data relating specifically to Bassetlaw is not included due to the changes in ICS footprint i.e. *Bassetlaw will move into Nottingham and Nottinghamshire ICS.'* (DHSC. 2021).

Population demographics

Across Y&tH the local authorities vary in terms of their size and population demographics, with some areas having a differential proportion of children, working age adults and older adults (Table 2) and the distribution of that population within the geography (Figure 2).

There are densely populated areas of South Yorkshire which presents challenges for the planning and delivery of dental services, including location and distribution of services and recruitment and retention of dental team members.

Table 3 summarises the predicted trends in population demographics at ICS level across Yorkshire & the Humber between 2020-2040 (see also Appendix – population Tables A-E). Over the next two decades, the all age population of Yorkshire and the Humber is expected to increase by 6%. Similar increases are expected in most Y&tH local authorities. The populations of all local authorities in South Yorkshire are expected to increase at a rate greater than that of Yorkshire and the Humber. In most Local Authorities the falling birth rate is reflected in the predicted reduction in the child population, with the exception of Rotherham, Sheffield, Barnsley.

Of most significance is the predicted 33% increase in the population of older adults (65+ years), across Y&tH and 66% increase in the population of 85+ age group which is consistent across all Local Authorities. This highlights the need to develop dental services that meet the dental needs of this ageing population in terms of managing patients with co-morbidities and polypharmacy, training for the dental team and estates (refer to section on adult oral health).

Challenges exist in the mechanisms that are available to enable the commissioning of dental services that align with population growth.

Table 2 Population of Y&tH by local authority and SY ICS by age group, 2020.

LA / ICS	All ages	0-19	20-64	65+	85+
South Yorkshire	**1,415,054**	**328,263**	**830,705**	**256,086**	**32,561**
Barnsley	248,071	56,154	143,257	48,660	5,750
Doncaster	312,785	73,197	179,264	60,324	7,427
Rotherham	264,984	62,673	149,923	52,388	6,223
Sheffield	589,214	136,239	358,261	94,714	13,161
Y&tH	**5,526,350**	**13,330,355**	**32,755,764**	**1,042,314**	**133,392**
ENGLAND	56,550,138	1,303,008	3,181,028	10,464,019	1,406,410

Table 3: Predicted change in population for Y&tH by local authority and SY ICS (2020-2040)

LA / ICS	% change 2020-2040				
	0-19 years	20-64 years	65+ years	85+ years	All ages
South Yorkshire	**1%**	**4%**	**32%**	**60%**	**8%**
Barnsley	1%	3%	42%	76%	10%
Doncaster	-5%	2%	35%	65%	7%
Rotherham	2%	3%	28%	70%	7%
Sheffield	5%	6%	27%	44%	9%
Y&tH	**-2%**	**0%**	**33%**	**66%**	**6%**

Deprivation

The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation in England and is part of a suite of outputs that form the Indices of Deprivation (IoD). It follows an established methodological framework in broadly defining deprivation to encompass a wide range of an individual's living conditions.

Deprivation is one measure of the diversity of the population of Yorkshire and the Humber. More deprived areas are found in highly populated urban areas and along the North Sea coast. Deprivation is strongly correlated with poor oral health, particularly tooth decay (all ages) and oral cancer in adults.

Ethnicity

Ethnicity is an important factor to consider in relation to oral health inequalities but the impacts upon oral health are further complicated due to variability in findings from research highlighting the need for further investigation. There are ethnically diverse populations

across Yorkshire and the Humber and local knowledge will be important to identify any oral health inequalities within communities.

Table 4 Ethnicity variations by local authority in Yorkshire & the Humber for SY ICS (source ONS census 2011)

Local authority/ICS	White	Mixed/multiple ethnic group	Asian/ Asian British	Black/African/ Caribbean/Black British	Other ethnic group
South Yorkshire					
Barnsley	97.76%	0.59%	0.84%	0.59%	0.23%
Doncaster	95.20%	0.86%	2.66%	0.85%	0.42%
Rotherham	93.83%	0.69%	4.06%	0.88%	0.54%
Sheffield	84.07%	1.73%	8.47%	3.60%	2.14%

Oral Health of Children

Oral health of 3-year-old children

The second national survey of 3-year-old pre-school children, attending nurseries, both private and state funded, nursery classes attached to schools and play groups was carried out in 2020. Although most three-year-old children were free from visually obvious tooth decay, the proportion of children experiencing tooth decay in Yorkshire and the Humber was 14.7% which is higher than the national figure of 10.7% and the worst region in the country. When data are examined at local authority level in SY ICS, the prevalence of tooth decay was lowest in Sheffield (0.9%) (Table 5).

In the Doncaster local authority area cessation of the survey due to the COVID-19 pandemic meant that the field work teams were unable to visit any nurseries. Therefore, the results should be interpreted with caution.

Table 5: Oral health experience of 3-year-olds in Yorkshire and the Humber, 2020

Upper-Tier LA Name/ICS	% $d_3$mft>0 including Incisors	Mean $d_3$mft inc Incisors ($d_3$mft>0 inc Incisors)	% with incisor caries	Care Index % inc Incisors (ft/$d_3$mft including Incisors)	% with pufa
South Yorkshire					
Barnsley	10.8	††	5.4	0.0	0.0
Doncaster***					
Rotherham	16.2	2.4	4.7	4.3	0.0
Sheffield	0.9	††	0.0	0.0	0.4
Y&tH~	14.7	2.9	3.9	4.6	0.5
England	**10.7**	**2.9**	**3.4**	**4.4**	**0.4**

*Did not participate in survey
**Includes Craven
***LAs did not visit any nurseries due to Covid-19
†Based on fewer than 30 volunteers with decay experience
††Insufficient numbers for estimate
~Excludes Doncaster; East Riding of Yorkshire; Kingston Upon Hull; Kirklees; York
PUFA – presence of pain, ulceration, fistulae or abscess – a measure of sepsis

Oral health of 5-year-old children

In 2019 the prevalence of tooth decay (% dmft>0) in five-year-old children in Y&tH was the second highest in the country with 29% of children examined experiencing tooth decay (England-23%) (Table 6). Within SY all Local Authorities have a disease prevalence which is greater than England and Y&tH (Table 6).

Table 6: Oral health experience of 5-year-olds in Yorkshire and the Humber, SY ICS 2019

Local Authority / ICS	% $d_3$mft > 0	Mean $d_3$mft ($d_3$mft > 0)	% with sepsis	% with incisor caries	Care Index % (ft/$d_3$mft)
South Yorkshire					
Barnsley	39.6	4.1	1.9	11.3	8.9
Doncaster	37.2	3.7	3.0	9.3	11.1
Rotherham	31.6	3.5	1.2	9.7	7.4
Sheffield	41.0	4.0	1.2	15.4	7.2
Yorkshire and the Humber	**28.7**	**3.8**	**1.4**	**7.6**	**9.2**
England	**23.4**	**3.4**	**1.0**	**5.2**	**10.3**

Hospital dental extractions

Tooth decay is still the most common reason for hospital admissions in the 6-10-year old age group (PHE, 2021) Hospital tooth extractions of 0 to 19 year olds - GOV.UK (www.gov.uk).

Across England during 2019/20 there has been a 5.9% reduction in the number of episodes of caries-related tooth extractions in hospital for 0 to 19-year olds compared to the previous year, despite a 0.3% increase in the estimated population of this age group. The reduction is mainly due to the significant drop in the number of admissions for tooth extractions in March 2020. This is consistent with the reduction for all admissions to hospital during this month because of the SARS-CoV-2 outbreak.

Children from deprived backgrounds are more likely to access these services, a reflection of the inequality of distribution of dental caries in the population.

The proportion of 0-19-year olds having GA for extraction is higher than England for all local authorities in South Yorkshire as is the proportion of 0-19, 0-5- and 6-10-years having GA for extraction with tooth decay as the primary diagnosis (Table F appendix). Note - caution in interpreting this data as activity from Hull and East Riding is not captured in HES data.

Oral health of adults

Oral health survey of adults attending general dental practices, 2018

Adults (16+ years) attending general dental practices for any reason, were recruited to take part in the Oral health survey of adults attending general dental practices 2018 (PHE.2020), the first of its type. The survey consisted of a questionnaire on the impact of oral problems on individuals, use of dental services and barriers to receipt of care and a brief clinical

examination conducted by trained local epidemiology teams under standardised conditions (data relating to SY can be found in table G in the appendix).

Mildly Dependant Older Adults (2016)

In response to the increasing proportion of older people in the population and the need to understand the oral health needs of community dwelling older people in the context of their particular health and social care needs, in 2015 the National Dental Epidemiology Programme for England (NDPHEP) undertook the first dental epidemiological survey of adults living in supported housing and which explored their oral health and dental service use Oral health survey of mildly dependent older people 2016 - GOV.UK (www.gov.uk).

The method was implemented as a pilot and as there is no directly comparable data to use which could help to show trends, information from the England data subset of the 2009 Adult Dental Health Survey (ADHS) (ONS.2011) (Adult Dental Health Survey 2009 - Summary report and thematic series - NHS Digital) was used to give broad comparators, but the results provide baseline data for this population.

There was general consistency in the findings across this survey and the ADHS. Across all variables reported Y&H was broadly similar to England, but there were some variations at local authority level.

Highlighted key findings with a SY focus include:

Oral health

- 9% of participants reported having oral pain on the day of the examination while 8% were found to have an open pulp, ulceration, fistula or an abscess **(Y&H – 10.7%, Rotherham – 27%)**.
- 27% were edentulous (no natural teeth) **(Doncaster – 53.8%)**.

Treatment need and service use

- 14.8% had full dentures in need of replacement **(Y&H – 14.8%, Doncaster – 25.9%, Sheffield – 25%).**
- 13% had partial dentures in need of replacement **(Y&H – 15.1%, Doncaster – 41.2%)**.

Oral Cancer

In 2020 PHE published a first report describing the incidence, survival and mortality rates for oral cancer in England, 2012 to 2016 (PHE, 2020). The report uses two categories for reporting based on International Classification of Diseases (ICD) version 10: lip, oral cavity and pharynx (C00-C14) and oral cavity (C00- C06). The latter grouping features cancers of sites likely to be visible in a dental examination. Note - the report excludes the very low incidence of malignant head and neck neoplasms of bone (C41) or soft tissue (C45-C49) which may occur in the mouth and in situ or benign neoplasms of uncertain behaviour. The latter may be under-recorded in the cancer registry but are important to note as these and pre-cancerous conditions contribute to dental referrals for investigation.

In England from 2012 to 2016 there were 35,830 new cases of oral cancer diagnosed and 10,908 deaths (PHE. 2020). Incidence and mortality rates for oral cancer have risen in recent years and there are stark inequalities between geographic areas and population groups. Source: Oral cancer in England: a report on incidence, survival and mortality rates of oral cancer in England, 2012 to 2016 (publishing.service.gov.uk)

Incidence of C00-C14 in Y&tH was higher than for England overall. The majority of lower-tier local authority areas in which incidence was greater than for England were densely populated urban centres in the North (Table H appendix).

Mortality due to C00-C14 in Y&H was higher (NS) than the England rate. At lower-tier local authority level the areas in which mortality was less than the England rate were typically rural and those in which it was greater than for England were typically urban. Mortality was greater than the England rate in lower-tier local authority areas covering densely populated cities (Table H appendix).

There was evident variation in incidence and mortality between income deprivation quintiles with rates increasing steadily as income deprivation increases.

Oral Health Inequalities

Oral Health inequalities

The PHE inequalities in Oral Health in England (PHE, 2021) document outlines the various dimensions of inequality. Key summaries and relevant sections of the document are outlined below and have been used to:

- Identify those groups and individuals where oral health inequalities exist
- Understand the impact of those inequalities upon oral health such as increased oral disease and/ or barriers accessing dental care

Barriers to dental service use have been found for those with protected characteristics and vulnerable groups at individual, organisational and policy level although availability of data is variable (Table 9).

Table 9: Scoping Review of oral health inequalities in the UK: overview of findings (PHE 2021)

	Caries	Odontogenic infections	Tooth loss	Oral cancer	Periodontal disease	Traumatic dental injuries	Self-rated oral health or pain	OHRQoL	Oral health related behaviours	Service use
SEP	++	n.d.	++	++	inc.	inc.	++	++	++	++
Area deprivation	++	+	++	++	inc.	–	+	++	+	++
Ethnicity	+	n.d.	+	+	inc.	–	inc.	+	inc.	inc.
Disability	+	n.d.	+	n.d.	inc.	+	–	+	+	+
Pregnancy/ maternity	n.d.	n.d.	inc.	n.d.	inc.	n.d.	inc.	n.d.	inc.	inc.
Religion	inc.	n.d.	n.d.	n.d.	n.d.	n.d.	n.d.	n.d.	n.d.	n.d.
Homelessness	+	+	+	+	+	+	+	++	+	+
Prisoners	+	+	n.d.	n.d.	+	n.d.	+	++	inc.	+
Travellers	+	n.d.	n.d.	n.d.	n.d.	n.d.	n.d.	n.d.	+	+
Looked-after children	+	n.d.	n.d.	n.d.	n.d.	+	+	n.d.	n.d.	+

++ Strong evidence for inequalities
+ Evidence for inequalities based on limited data
– No evidence for inequalities
inc. Mixed or inconclusive evidence
n.d. No data

Protected characteristics

Disability (including poor Mental Health)

Disability is defined as a 'physical or mental impairment that has a substantial and long-term negative effect on the ability to do normal daily activities. Disability is a protected characteristic and defined in the Equality Act 2010.

There is some evidence to show oral health inequalities related to disability and tooth decay, tooth loss, dental traumatic injuries, oral health quality of life, oral health related behaviours and service use (lower dental attendance). These groups may be more challenging to treat with some requiring specialist input.

Table 10 outlines the prevalence of some disabilities in the Y&tH region from data that was available.

Table 10: **PANSI data 2021 for data relating to the prevalence of protected characteristics and health inequalities for those aged those aged 18-64 years of age**

Inequality	**% of 2020 population in Y&tH predicted to be affected**
Common mental health disorder	19%
Downs Syndrome	0.06%
Severe Hearing Impairment	0-1%
Learning Disability	2.4%
Autistic Spectrum Disorders	1%
Impaired Mobility	5-6%

Children with learning and/or physical disabilities in residential schools

Oral health leads from Local Authorities were invited to provide data on residential schools for children with learning or physical disabilities (Table I appendix). Based on this data, there are just under 500 children with various disabilities living in residential schools across the region (for South Yorkshire ICS there are around 152 children aged 3 to 25, further details can be found in the appendix table I).

Vulnerable groups

Evidence suggests that vulnerable groups such as homeless people, prisoners, Gypsy, Roma and Traveller communities, refugees and looked after children have poorer oral health and have considerable difficulty accessing care (Table 9). Homeless people have higher levels of untreated decay and periodontal disease and poorer oral health related quality of life than the general population.

Further detail in relation to people with longstanding medical conditions, migrants, asylum seekers, resettled refugees, unaccompanied asylum-seeking children (UASC) and Roma Community can be found in the appendix (including tables J and K).

Homeless

The highest prevalence of statutory homelessness across Yorkshire and the Humber can be found in larger cities like Sheffield and in areas such as Doncaster. Source: *PHE fingertips Statutory homelessness (eligible people not in priority need) in Y&tH by District & UA 2017/2018*

Dental Access

Access to NHS dentistry in SY ICS and the impact of the COVID-19 pandemic

Data from NHS Digital reveals variation in access as a proportion of the population for adults and children by upper tier local authority in SY ICS (see table 11)

Table 11: Patients seen in the previous 24 months and child patients seen in the previous 12 months as a percentage of the population, by patient type and LA up to 30th June 2021.

Local Authority / ICS	Adult (18 years and older)	Child (0-17.99 years of age)
South Yorkshire		
Barnsley	51.7	32.4
Doncaster	53.4	33.1
Rotherham	51.4	32.3
Sheffield	53.0	36.7

Impact of COVID-19 on NHS dental access

The dental sector has faced challenges since March 2020 at the start of the pandemic due to the relatively high proportion of aerosol generating procedures (AGPs) undertaken. Initially dental practices were asked to close and urgent dental centres (UDCs) were established for patients in pain.

Practices reopened for the provision of face to face care in June 2020 and have steadily increased the activity that they can provide since then. The Chief Dental Officer asked dental primary dental care to prioritise patients according to their clinical need, due to reduced capacity. The starting point was a requirement to deliver at least 20% of normal activity volumes and this has gradually increased to a current minimum of 85% of pre-Covid activity until March 2022. Whilst restoration of NHS dental activity continues, it will be some time before dental services return to providing care at previous activity levels, with many dental practices still catching up on a backlog.

COVID-19 has had an impact upon individuals accessing health services including dentistry. A methodology identifying unique patients as a proxy measure for access was developed in the North East of England to explore the impact of the pandemic on NHS dental access.

In Yorkshire & the Humber there was a decrease by 81% (74% - England) in the proportion of children (aged 0-17 years) accessing NHS primary dental care and for adults (18 years and over) a decrease of 73% (68% - England)

Within Y&tH, variations in the proportion of the population of children (aged 0-17 years of age) and adults accessing primary NHS dental services were apparent between local authorities in SY ICS (see table 12).

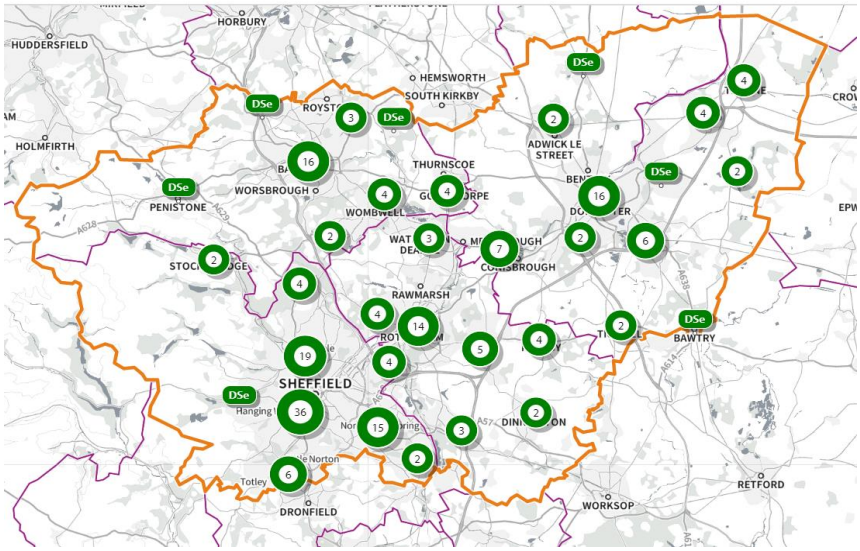
Table 12: Proportion of the population (0-17 and 18 years and over) in Local Authorities in ST ICS (expressed as a percentage) accessing primary dental care between Jul-Dec 2019 and Jul-Dec 2020

Local Authority / ICS	Proportion of 0-17 population accessing services Jul-Dec 2019	Proportion of 0-17 population accessing services Jul-Dec 2020	Proportion of adult population accessing services Jul-Dec 2019	Proportion of adult population accessing services Jul-Dec 2020
South Yorkshire	50%	9%	35%	9%
Barnsley	50	7	35	8
Doncaster	48	9	37	10
Rotherham	52	9	39	10
Sheffield	50	10	33	9

NHS Dental Care sites

Using the SHAPE mapping tool to provide a broad outline of the location of NHS dental practices/sites of care

Figure 8 South Yorkshire ICS NHS dental sites



Patient Engagement

The summary below outlines the views, experiences and concerns raised via public and patient engagement from across the SY ICS. Data was not available for every local authority area, but it is acknowledged that there may be on-going workstreams by groups representing patients such as Healthwatch, third parties and by Local Authorities.

It is important to note that whilst there are important issues of concern there has also been positive feedback from patients accessing NHS dental care including experiences of being made to feel welcome, staff were helpful and they felt safe with reports that dentists were taking appropriate cross infection control measures to protect staff and patients.

Areas of concern are common across the region and relate primarily to access, availability, affordability and communication relating to NHS dental services. Reports acknowledge the challenges encountered during the COVID-19 pandemic but recommend different commissioning approaches to address the areas of concern.

Table 15 Summary of challenges highlighted by Y&tH Healthwatch in SY ICS areas in relation to dental access

LA/ICS	Source of data	Main areas of concern	Recommendations
Sth Yorkshire			
Sheffield	Healthwatch	NHS Dental Services: • Access • Communication of services available *(particularly during the pandemic)*	Addressing the concerns raised

N.B. Reports have been aligned with closest ICS geographical footprint.

Recommendations aligned with life course approach

Infancy and Early Years

Infants and young children with experience of tooth decay are more likely to have poorer oral health throughout their lifetime. Tooth decay causes pain, affects eating and leads to time off school for children and time off work for carers. It is important they get the best start in life by:

- Universal implementation and promotion of the of Dental Check by One (DCby1) and for further reviews at least once a year thereafter.
- Maximising the skill mix of the dental workforce to deliver oral health preventive messages including oral hygiene, diet advice and applying fluoride varnish.
- Using evidence based oral health improvement programmes including distribution of toothbrushing packs, supervised tooth brushing schemes, and training the wider early years workforce to deliver oral health prevention to those at high risk and facilitate access to NHS dental care.

Childhood and Adolescence

Oral health improvement programmes are essential to support families in developing good oral health practices, but provision varies across the region and there is a need to address inequities to programmes.

Working age and adults

- Partnership working across the health and social care system, maximising the skills of the wider health and social care workforce can help to reduce those risks by making every contact count including signposting patients to services dedicated to mental health, diabetes, stop smoking, drug and alcohol and in achieving and maintaining a healthy weight.

Older People

- Good oral health is important for quality of life, nutrition and hydration and is linked with general health. Poor oral health has been linked with aspiration pneumonia, poor diabetes control and heart disease.
- An ageing population across the whole region will put pressure upon dental services. Prevention is key. As people retain teeth for longer, the maintenance of a heavily restored dentition is complicated and expensive, and often compounded by failing general health, polypharmacy causing a dry mouth, and the ability to self-care. It is essential that those who care for others are trained to provide mouthcare and dental services meet the needs of patients who are housebound.

- Dental services for older people must be more integrated within the wider health and social care landscape. This will need to be supported by developments in training, information sharing and referral pathways.
- In order to develop holistic patient-centred services, varying levels of prevention and care need to be available as part of the same care pathway. This may mean a service providing domiciliary care for routine prevention and simple treatments, plus access to public transport and multi-specialist centres for more complex treatments.

Increasing integration with general medical and social services for older adults would mean that patients with progressive long-term conditions could receive a dental assessment and treatment plan when their long-term condition is diagnosed. This would allow a proactive approach to ensure the patient is dentally healthy before their general health makes treatment provision difficult and would facilitate earlier access to dental staff with experience of providing dental care for older adults and knowledge of the complexities involved.

Top priorities and recommendations for reducing oral health inequalities in all ICS footprints:

Particular consideration could be given to those that have both the greatest dental need and experience challenges in accessing routine and urgent dental care including individuals and communities that are deprived and vulnerable children known to the social care system, individuals with severe physical and/or learning disabilities, poor mental health, older adults, homeless, asylum seekers, refugees and migrants. Data and evidence surrounding oral health inequalities is variable and complex, but we know that they also exist in relation to oral cancer and also in vulnerable groups with long-standing medical conditions, substance misuse, prisoners/prison leavers and Gypsy, Roma, and Traveller communities.

As a priority, a Community Dental Service (CDS), service review should encompass the entire special care dentistry and paediatric pathway and consider benefits of a Referral Management System (RMS). A service review of prison dental services in Yorkshire and the Humber is being undertaken separately. Considering the complex needs of the older and ageing population, care pathways for housebound or those living in residential and nursing settings should be reviewed. The review of current dental services for people with no fixed abode in Y&tH can be used to inform robust care pathway design, commissioned models and support implementation.

Available Healthwatch reports were used to inform the rapid needs assessment. It is important that commissioned dental services including service design and development work consider the views, beliefs, and experiences of the public and patients living in Y&tH to improve patient safety, experience, and health outcomes. Building on work to date, NHSEI should continue to work in partnership with key stakeholders, including Healthwatch to maximise opportunities to ensure patient centred services improve access, reduce inequalities in communities and make better use of resources.

Recommendations for reducing oral health inequalities - all ICS footprints

Common Risk Factor Approach

Oral health messages need to be incorporated through a common risk factor approach into all health promotional programmes and included in health assessments for vulnerable groups, including MECC, brief interventions and signposting.

Prevention

Targeted prevention particularly aimed at reducing tooth decay, gum disease and preventing oral cancer in line with evidence based national guidance and toolkits. Screening of the oral mucosa for oral cancer/pre-cancer at dental appointments with referral to specialist services where necessary.

Improving access
Targeting resource to those with the greatest need and which experience the greatest challenges accessing care including those requiring urgent dental care.

Acknowledging the impact of COVID-19 on dental access to all, however, those in the most deprived areas with greatest need will experience the greatest impact.

A health equity audit approach should be used to determine equity of access to dental services and evaluate the outcomes from initiatives to improve access across Y&tH, the findings of which should inform future commissioning decisions.

Encourage development of child friendly practices and universal implementation and promotion of *Dental Check by One* (DCby1) with as a minimum, annual reviews thereafter.

Consideration of new or recommissioned practices in areas of deprivation supported by good public transport facilities and disabled parking.

Training
Maximising deployment of skill mix within the dental workforce, enables them to deliver oral health preventive messages including oral hygiene, diet advice and apply fluoride varnish aided by audit and learning from Starting Well, In Practice Prevention and flexible commissioning schemes.

For children in deprived areas training the wider early years workforce to deliver oral health prevention to those at high risk and facilitate access to NHS dental care. Encouraging Starting Well - whole family approach core elements.

Bespoke training for example training or support to individuals with autistic spectrum disorders can facilitate patient care for those with disabilities in General Dental Services (GDS).

Alignment of training:

- With the recommendations from Health Education England's *Advancing Dental Care Review.*
- Centres for training dental professionals should be prioritised to areas with the greatest oral health need and gaps in service provision to support reduction in oral health inequalities. Commissioning arrangements that enable trainees to gain experience in settings with the greatest oral health inequalities will be important.
- Numbers in dental training and specialist training posts should align with high needs groups that require special care and with medium to long term commissioning plans.

Understanding of the skills, work patterns and distribution of the dental work force with insight into their future aspirations and career plans to inform workforce planning, recruitment, and retention of dental professionals

Reducing oral health inequalities in older people

Training
Training of the primary care dental workforce to support delivery of care for the changing demographic of the Y&tH population acknowledging the predicted increase in the older population. This would involve partnership working across the health and social care system to facilitate a reduction in oral health inequities in the population. This could involve development of multi-disciplinary special care teams, led by MCNs, offering opportunities for dental professionals to up-skill (e.g. foundation training, PLVE and Level 2 training), by working alongside specialists and those with level 2 specialist skills with high needs groups

and identification and training of oral health care champions within care homes. Bespoke training in dementia friendly training can facilitate patient care of older adults in GDS.

Service and care pathways
In order to develop holistic patient-centred services for the older population, varying levels of prevention and care need to be available as part of the same care pathway. This may mean a service providing domiciliary care for bed bound patients including routine prevention and simple treatments, plus access to transport (including public transport) and multi-specialist centres for more complex treatments. Treatment may include a mix of mandatory and additional services and could be supported by oral health champions in practices and care homes. Increasing integration through the sharing of information and appropriate referral pathways could enable alignment between general medical and social services for older adults with dental services. This would mean that patients with progressive long-term conditions could receive a dental assessment and treatment plan when their long-term condition is diagnosed. This would allow a proactive approach to ensure the patient is dentally healthy before their general health makes treatment provision difficult and would facilitate earlier access to dental staff with experience of providing dental care for older adults and knowledge of the complexities involved.

Collaborative work across systems including NHSE and Local Authorities
Partnership working across the health and social care system, through a community approach maximising the skills of the wider health and social care workforce can help to reduce risks by making every contact count. Oral health improvement programmes are essential to support families in developing good oral health practices, but provision varies across the region and there is a need to address inequities in access to and content of programmes. Complementary commissioning is important between Local Authorities and NHS E&I. Where gaps are identified working with Primary Care Network (PCN) leadership will be important to support alignment of services and strengthen collaboration across the totality of primary care. Improved data collection and integration of digital systems, with simplified processes should be explored to benefit the safeguarding and oral health of vulnerable children and adults.

For consideration by Local Authorities (LAs)
Oral health improvement programmes should be evidence-based and quality assured, audited and evaluated. Water fluoridation is an evidence based and a cost-effective approach, and LAs are currently responsible for feasibility studies.
Commission oral health surveys to monitor the oral health of the whole population and participate in any oral health survey commissioned by the secretary of state.

Service provision and care pathways
Commissioning strategies will have the biggest impact on those at greatest risk of oral health inequities if the approach focusses on both prevention and treatment. Outcomes are poorer in those groups with identified oral health inequalities. Procurement of services and service re-design should be underpinned by service reviews, needs assessments, and informed by national guidance and best practice. There is a need to understand and agree key actions to address oral health inequalities. National dental epidemiological programmes provide valuable data in relation to oral health inequalities and Local Authorities should work in partnership with NHSE to explore opportunities for joint approaches to commissioning and contracting models to support collection of local data as part of the national dental epidemiology programme and address the data gaps identified in this needs assessment.

An initial focus should be upon a full review of services such as the CDS including the special care and paediatric pathways and access to domiciliary care provision (nursing and residential homes or in their own home), aligned with reducing oral health inequalities. This will support further exploration of opportunities for specialist led pathway development

informed by Managed Clinical Networks (MCNs), including progress toward shared care development, integrating dental care between GDS, CDS and secondary care. Quality assurance through audit, could be led by MCNs.

Dental services are not equitably distributed and provide different levels of service provision. Challenges accessing dental care is reported by patient groups from across the region, but need does not always align with demand. Dental services should be accessible for people with physical and learning disabilities for example ensuring that new practices are in areas with disabled parking.

An inclusion health approach with incorporation of models beneficial to various vulnerable groups particularly those that encounter challenges accessing services and have high need (for example individuals with Severe Multiple Disadvantage) through dedicated stabilisation and urgent care drop-in care sessions. These also provide an opportunity for training/up skilling of dental professionals and reducing inequalities with groups including migrants, asylum seekers, refugees, Gypsy, Roma, and Traveller communities, and the homeless. Innovative approaches in Y&H such as flexible commissioning for prevention and access programmes, have been introduced in an attempt to reduce oral health inequalities and to maximise delivery and spend of the dental budget. A review of the flexible commissioning model and existing time limited interventions can be used to inform further development or expansion of existing interventions.

Supporting all contractors to maximise delivery of their contracted activity and minimise clawback is beneficial for patients, providers and commissioners. Where contracts are returned to NHS England this should be used as an opportunity to address oral health inequities locally. The voice of the patient and public should be a standard part of the development of specifications for dental services and commissioning approaches should continue to be informed by patient responses.

Recommendations at ICS level

The development of ICSs offers the opportunity for action planning with key partners across each ICS footprint with priority setting and exploration of opportunities to reduce oral health inequalities. Further work at ICS level will be needed in relation to systems to collate data on an ICS footprint to enable mapping and understanding of current service provision (including urgent dental care) with need, deprivation and existing time limited initiatives.

ICS – South Yorkshire – recommendations for additional focus:
Trends in tooth decay amongst 5 year olds, Deprivation, Vulnerable groups – Children in deprived areas and vulnerable children known to social care, the homeless, Gypsy, Roma and Traveller communities, and asylum seekers/resettled refugees

Alignment with Core20PLUS5 – Y&tH

Model applied to Y&tH at ICS level

- **CORE** – all ICS - The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD) – strong evidence base
- **PLUS**
    - All ICSs - those with greatest need and those experiencing challenges accessing dental care
        - Vulnerable children
        - Physical and learning disabilities
        - Older adults – significant predicted population increase across all ICS footprints
        - Asylum seekers, migrants and refugees

- SY – Prevention to reduce dental decay levels in children and homeless in Doncaster and deprived areas with greater ethnic diversity e.g. Sheffield

- **5**
  - All ICS - Oral cancer diagnosis – importance of role of GDS

Appendix

Population Demographics

Table A: Population of Y&tH by local authority and SY ICS for all ages between 2020-2040

Local Authority / ICS	ALL AGES					
	2020	2025	2030	2035	2040	% change 2020-2040
South Yorkshire	**1,419,395**	**1,452,639**	**1,483,081**	**1,511,302**	**1,537,806**	**8%**
Barnsley	248,707	256,164	262,376	268,202	274,052	10%
Doncaster	313,762	320,194	324,963	329,641	334,626	7%
Rotherham	267,215	272,899	277,482	282,030	287,078	7%
Sheffield	589,710	603,383	618,261	631,430	642,050	9%
Y&tH	**5,528,103**	**5,623,321**	**5,705,872**	**5,778,521**	**5,847,468**	**6%**

Source: ONS Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)

** includes Craven

Table B: Population of Y&tH by local authority and SY ICS for adults (0-19 years) between 2020-2040

Local Authority / ICS	0-19 years					
	2020	2025	2030	2035	2040	% change 2020-2040
South Yorkshire	**330,749**	**337,980**	**335,378**	**331,908**	**335,150**	**1%**
Barnsley	55,977	57,289	56,722	55,805	56,305	1%
Doncaster	72,894	73,574	71,475	69,573	69,533	-5%
Rotherham	62,995	64,373	63,857	63,241	64,051	2%
Sheffield	138,883	142,744	143,325	143,290	145,261	5%
Yorkshire & the Humber	**1,308,399**	**1,327,093**	**1,306,195**	**1,279,107**	**1,283,610**	**-2%**

Source: ONS Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)

** includes Craven

Table C: Population of Y&tH by local authority and SY ICS for adults (20-64 years) between 2020-2040

Local Authority / ICS	20-64 years					
	2020	2025	2030	2035	2040	% change 2020-2040
South Yorkshire	830,781	836,593	843,806	850,924	861,897	**4%**
Barnsley	143,681	144,663	145,183	145,940	148,051	3%
Doncaster	180,161	180,160	180,138	181,043	183,106	2%
Rotherham	151,183	151,384	151,719	152,609	155,024	3%
Sheffield	355,757	360,387	366,766	371,332	375,716	6%
Yorkshire & the Humber	**3,173,930**	**3,162,912**	**3,154,947**	**3,156,717**	**3,169,407**	**0%**

Source: ONS Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)

** includes Craven

Table D: Population of Y&tH by local authority and SY ICS for older adults (65+years) between 2020-2040

Local Authority / ICS	65+ years					
	2020	2025	2030	2035	2040	% change 2020-2040
South Yorkshire	**257,864**	**278,066**	**303,898**	**328,470**	**340,759**	**32%**
Barnsley	49,050	54,212	60,471	66,457	69,696	42%
Doncaster	60,707	66,460	73,350	79,025	81,987	35%
Rotherham	53,037	57,142	61,907	66,180	68,003	28%
Sheffield	95,069	100,252	108,170	116,808	121,074	27%
Yorkshire & the Humber	**1,045,774**	**1,133,317**	**1,244,730**	**1,342,697**	**1,394,451**	**33%**

Source: ONS Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)

** includes Craven

Table E: Population of Yorkshire & the Humber by local authority and SY ICS for older adults (85+years) between 2020-2040

Local Authority / ICS	85+ years					
	2020	2025	2030	2035	2040	% change 2020-2040
South Yorkshire	**33,079**	**36,410**	**41,271**	**49,570**	**52,794**	**60%**
Barnsley	5,880	6,531	7,688	9,448	10,340	76%
Doncaster	7,473	8,094	9,116	11,323	12,361	65%
Rotherham	6,431	7,432	8,698	10,431	10,937	70%
Sheffield	13,295	14,353	15,769	18,368	19,156	44%
Yorkshire and the Humber	**134,127**	**148,702**	**167,898**	**208,621**	**222,988**	**66%**

Source: ONS Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland - Office for National Statistics (ons.gov.uk)

** includes Craven

Child oral health

Table F: Summary of FCE for all extractions and extractions with caries as the primary diagnosis for 0-19 years from 2017/18 to 2019/20.

Local Authority / Integrated Care System of residence	FCE's for extractions as a % of the total population (all diagnoses)			FCE's for extractions as % of population with caries as the primary diagnosis			FCE's for extractions as % of population with caries as the primary diagnosis			FCE's for extractions as % of population with caries as the primary diagnosis			Number of FCE's for extractions with caries as the primary diagnosis		
	(0-19 years)			(0-5 years)			(6-10 years)			(0-19 years)			(0-19 years)		
	17/18	18/19	19/20	17/18	18/19	19/20	17/18	18/19	19/20	17/18	18/19	19/20	17/18	18/19	19/20
South Yorkshire															
Barnsley	1.2%	1.0%	1.0%	1.2%	0.8%	0.8%	2.0%	1.8%	1.9%	1.0%	0.9%	0.9%	100	85	65
Doncaster	1.5%	1.2%	1.3%	1.3%	1.1%	1.0%	3.0%	2.3%	2.8%	1.4%	1.1%	1.2%	125	110	100
Rotherham	1.6%	1.2%	1.4%	1.5%	1.1%	1.2%	2.7%	2.1%	2.5%	1.3%	1.0%	1.2%	150	125	120
Sheffield	1.4%	1.2%	1.2%	1.2%	1.0%	0.9%	2.2%	2.0%	2.1%	1.1%	1.0%	0.9%	395	300	340
ENGLAND**	**0.5%**	**0.4%**	**0.4%**	**0.3%**	**0.3%**	**0.3%**	**0.6%**	**0.6%**	**0.5%**	**0.3%**	**0.3%**	**0.3%**	**20,929**	**21,608**	**19,947**

* denotes figure <6 suppressed because of disclosure control. All other subnational figures rounded to the nearest 5
**England totals based on unsuppressed figures

Adult oral health

Table G: - Adult **o**ral health impacts in Yorkshire and the Humber 2018 by local authority

Upper-Tier LA Name	% functional dentition (21 or more teeth)	% active decay (DT>0)	Average number of decayed teeth (for those with	% with filled teeth	% with dentures	% with bleeding on probing	% with PUFA	% with any treatment need	% urgent treatment need	% not seen a dentist in the last 2 years	% suffering any oral health impacts (fairly or very often)
South Yorkshire											
Barnsley*											
Doncaster*											
Rotherham*											
Sheffield*											
Yorkshire and the Humber	**82.8**	**25.0**	**1.9**	**91.7**	**15.6**	**44.6**	**4.3**	**75.4**	**3.2**	**6.1**	**16.5**
England	**81.9**	**26.8**	**2.1**	**90.2**	**15.4**	**52.9**	**5.2**	**70.5**	**4.9**	**7.9**	**17.7**

* Did not participate in the survey
**North East Lincolnshire - insufficient numbers examined for estimate
^^ Includes Craven
PUFA – presence of pain, ulceration, fistulae or abscess – a measure of sepsis

Oral cancer

Table H: Standardised incidence and mortality of C00-C14 and C00-C06 by statistical region, upper-tier local authority area and lower-tier local authority area, 2012 to 2016.

Geography	C00-C14						C00-C06					
	Standardised incidence per 100,000	Lower 95% CI	Upper 95% CI	Standardised mortality per 100,000	Lower 95% CI	Upper 95% CI	Standardised incidence per 100,000	Lower 95% CI	Upper 95% CI	Standardised mortality per 100,000	Lower 95% CI	Upper 95% CI
England	**14.55**	**14.4**	**14.71**	**4.54**	**4.45**	**4.62**	**8.36**	**8.24**	**8.48**	**2.19**	**2.13**	**2.25**
Yorkshire & the Humber	**15.26**	**14.76**	**15.75**	**4.7**	**4.42**	**4.99**	**8.7**	**8.32**	**9.07**	**2.18**	**1.98**	**2.37**
South Yorkshire												
Barnsley	13.59	11.27	15.91	4.72	3.25	6.19	7.17	5.47	8.87	2.72	1.59	3.86
Doncaster	14.36	12.28	16.45	4.14	2.97	5.31	8.04	6.43	9.65	2.1	1.22	2.98
Rotherham	15.47	13.14	17.81	4.2	2.91	5.48	8.72	6.92	10.52	1.47	0.63	2.31
Sheffield	15.27	13.62	16.92	4.85	3.9	5.81	7.45	6.29	8.62	1.67	1.09	2.25

** includes Craven

† cells left blank as the rates are based on fewer than 10 cases and have been suppressed.

Rates statistically significantly lower than the England mean have been highlighted in green and rates statistically significantly higher than the England mean have been highlighted in red

Table I: Residential schools for children with learning or physical disabilities provided by Local Authorities in Y&H

LA/ICS	School	Numbers	Age range	Disabilities
South Yorkshire				
Barnsley	No residential schools			
Doncaster	Doncaster School for the Deaf	29	4 to 19	Hearing Impairment
	Fullerton House School	32	8 to 19	ASD, Severe Learning Difficulty
	Wilsic Hall School	30	11 to 19	ASD, Severe Learning Difficulty
Rotherham	Ellern Mede Moorgate School	12	under 18 to 25	Eating disorder facility
Sheffield	Brantwood Specialist School	49	7 to 19	Autism Spectrum Conditions, Pathological Demand Avoidance and Attachment Disorder

Migrants Asylum Seekers, Resettled refugees, Unaccompanied Asylum-Seeking Children (UASC) and Roma Community

Studies have indicated a high prevalence of oral disease and unmet oral healthcare needs in refugees, often exceeding the levels experienced by the most disadvantaged communities of the host country. Most commonly, refugees experience high levels of dental caries, periodontal disease, oral lesions and traumatic dental injuries (FDI. 2020).

Similarly, to the general population, people from migrant communities could be classified into 3 main groups in terms of their engagement with dental care services:

- People who wish to engage with services and require support to achieve dental fitness
- People who only wish to engage in case of an urgent need/pain
- People who do not wish to engage

When designing dental care pathways, some of the specific barriers for accessing care by migrants can be around:

- Language
- Prior beliefs about oral health
- Anxiety
- Understanding administration including exemption or partial exemption

The section below tables J and K are a summary of data kindly collated by Migration Yorkshire

Table J Summary of data relating to Asylum seekers, resettled refugees, Unaccompanied Asylum-Seeking Children and Roma Community in Y&tH – notes to accompany table K

Vulnerable group	Basis of Data/Data source	Data includes	Data excludes	Numbers dependent upon	Y&H Local Authority participation	Comments
Asylum seekers	Recipients of S95 Home Office support (whilst awaiting a decision on asylum claim)	'Dispersal' [individuals who are destitute and living in no-choice dispersal housing] and 'Subsistence only' [individuals	People who have had their claim refused but are still living in dispersal housing [under 'Section 4'], Unaccompanied children, and those whose cases are	Numbers arriving in the UK, the proportion that the Home Office send Y&tH to be accommodated, location of available housing/friends and family, timeframe for	Data reveals small numbers in Harrogate, North Lincolnshire and York possibly as part of temporary arrangements during the pandemic.	Permanent accommodation site - Wakefield up to 250 people on 'Section 98' support are housed temporarily for a matter of days/weeks until their longer term accommodation [S95 'dispersal' accommodation] in the community is allocated.

		receiving a subsistence allowance only - not housing] claimants.	considered closed.	case assessment and post-decision outcome.		
Resettled refugees	People resettled via Government resettlement schemes Home Office - cumulative count of resettled refugees since the start of the Vulnerable Persons Resettlement Scheme VPRS scheme (March 2014 to June 2021).	Prior to 2021, the resettled refugee data covered VPRS and the Vulnerable Children Resettlement Scheme (VCRS), From 2021, the VPRS and VCRS have been replaced by the UKRS. The resettled refugee data covers the UKRS as well as the Community Sponsorship scheme and the smaller schemes which were previously excluded.	Prior to 2021 data excluded the smaller numbers arriving under the Gateway Protection Programme (GPP) and the Mandate scheme. In 2021, new resettlement schemes for people from Afghanistan (ARAP and ACRS) were announced and have not yet been incorporated into any dataset.	Numbers arriving in the UK, how many people the local authority has offered to host, and whether the individuals' needs can be met in that area, such as housing size and adaptation for the family's physical needs, school places and appropriate medical care.	All have participated	Most resettled refugees to date have been Syrians arriving under the (VPRS).
Unaccompanied asylum-seeking children (UASC)	Department for Education - snapshot of UASC as of March 2020.	Spontaneous arrivals and children coming into care of Local Authorities through different formal schemes including the (VCRS) and the Dublin schemes.	Those in the Leaving Care system or on the National Transfer Scheme (NTS). Figures in Y&tH will have increased during 2021 due to the introduction of the NTS to relocate unaccompanied children from the South East to Local Authorities around the country.		All Local Authorities are potentially hosting unaccompanied asylum-seeking children and have a legal duty to provide accommodation.	UASC are children, who have applied for asylum in their own right and are separated from both parents and/or any other responsible adult.
Roma	Department of Education – School Census snapshot and rate as of 2020/21	State funded nursery, primary, secondary, special and pupil referral schools.	The ethnic category used in data collection includes 'Gypsy/Roma', which may include wider Gypsy groups, -	There is a separate category for 'Irish Traveller', so this group will not be included.		Challenges surrounding data collection Department of Education shows Yorkshire and Humber to have the second highest number of

			best indicator at this time.			school students who are Gypsy/Roma.

Data is provided at lower local authority level for asylum seekers and resettled refugees but only at upper tier local authority for unaccompanied asylum seeker children and Roma Travellers.

Table K Summary of data relating to Asylum seekers, resettled refugees, Unaccompanied Asylum-Seeking Children and Roma Community in Y&tH

Local Authority / ICS	Number of asylum seekers in receipt of S95 support (June 2021)	Number of resettled refugees (March 2014 to June 2021)	Mid Year Population Estimate (2020)	Number of asylum seekers in receipt of S95 support per 1,000 population (June 2021)	Number of resettled refugees per 1,000 population (March 2014 to June 2021)	Number of unaccompanied asylum-seeking children (UASC) looked after by the local authority (2020)	Number of unaccompanied asylum-seeking children (UASC) per 1,000 0-17 population looked after by the local authority (2020)	0-17 Mid Year Population Estimate (2020)	Number of students classified as White: Gypsy Roma (January 2020)	Percentage of students classified as White: Gypsy Roma (January 2020)
South Yorkshire										
Barnsley	346	23	248071	1.4	0.1	0	0	51621	65	0.002
Doncaster	243	19	312785	0.8	0.1	0	0	67362	432	0.009
Rotherham	465	38	264984	1.8	0.1	7	0.1	57453	564	0.012
Sheffield	858	402	589214	1.5	0.7	22	0.2	118398	1669	0.02

** Data relating to North Yorkshire cannot be aligned at ICS level as it includes data from Harrogate, Hambleton, Richmondshire, Ryedale, Scarborough, Selby which are all aligned with HCV but also includes data relating to Craven which is aligned with West Yorkshire ICS

Data from the School Census has been provided to indicate concentrations of the Roma population at local authority level. The ethnic category used is ‘Gypsy/Roma’, so this may cover some wider Gypsy groups, however this is the best indicator. People from Roma communities experience high levels of tooth decay, which may be linked to a traditionally high sugar diet.